DOCUMENT RESUME

ED 344 377 EC 301 104

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TITLE Approaches in the Treatment of Adolescents with Emotional and Substance Abuse Problems. Technical Assistance Publication Series Number 1.
INSTITUTION Alcohol, Drug Abuse, and Mental Health Administration (DHHS/PHS), Rockville, MD. Office for Treatment Improvement.
REPORT NO DHHS-(ADM)-91-1744
PUB DATE 91
NOTE 40p.
PUB TYPE Guides - Non-Classroom Use (055)

EDRS PRICE MF01/PC02 Plus Postage.
DESCRIPTORS *Adolescents; Alcohol Abuse; Counseling; *Delivery Systems; Demonstration Programs; Drug Abuse; *Emotional Disturbances; Epidemiology; Family Programs; Incidence; *Intervention; Models; Program Development; Program Effectiveness; Staff Development; *Substance Abuse

ABSTRACT

This report reviews the impact of substance abuse and mental health problems among the adolescent population, examines the research issues and treatment delivery system, identifies model modalities and programs to address the needs of adolescents, and makes practical recommendations on the implementation of effective treatment methods for youths. The first part of the report examines the epidemiological evidence regarding the prevalence and incidence of substance abuse and mental illness in adolescents, and outlines the categories of programs in the drug and alcohol and mental health systems. The second part describes 12 adolescent treatment programs, selected for their unusual or innovative approaches. The report concludes with general recommendations for the replication of innovative programs; the recommendations target project design, staff training and development, and work with families. (42 references) (JDD)

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Technical Assistance Publication Series Number 1

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Approaches in the Treatment of Adolescents with Emotional and Substance Abuse Problems

Technical Assistance Publication Series Number 1

Brahm Fleisch

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Alcohol, Drug Abuse, and Mental Health Administration
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This publication was written by Brahm Fleisch, in affiliation with the Bank Street College of Education, New York, New York, under purchase order number 89MF65934701D from the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA). Several individuals of the ADAMHA staff made significant contributions to this publication: Richard J. Bast, of the Office for Treatment Improvement (OTI), contributed technical writing; Elizabeth Rahdert, Ph.D., of the National Institute on Drug Abuse, reviewed the report; Anna L. Marsh, Ph.D., of OTI and Mr. Bast served as the ADAMHA project officers.

The opinions expressed herein are the views of the author and do not necessarily reflect the official position of OTI or any other part of the U.S. Department of Health and Human Services.

DHHS Publication No.
(ADM) 91-1744
Printed 1991

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Acknowledgments

This study would not have been possible without the active support of the many people we interviewed over the past few months. Program directors across the country in many programs we were unable to write about were very generous with their time and moral support. We would especially like to thank Steven Schwabish, Harry Kressler, Julia Glover, Thomas Olson, Janet Eldon, Kathleen Himsl, Leslie Acoca, Mary O'Sullivan-Evans, Betty Baron, Rod Mullen, Michel Kimball, and Robert Sewell, whose programs we have chosen to describe.

The groundwork upon which this study is based was conducted by Jeffrey Kushner, assistant director, Oregon Department of Human Resources, Office of Alcohol and Drug Abuse Programs. His extensive survey of State drug and alcohol abuse agencies, conducted in preparation for the National Adolescent Treatment Conference in October 1989 sponsored by the Office for Treatment Improvement (OTI), Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA), provided us with a large pool of innovative adolescent treatment programs, many of which we have chosen to feature in this study. Finally, I want to express my deep gratitude to Dr. Jane Knitzer, who not only provided useful guidance when I needed it but was a positive role model in her dedicated commitment to improving the lives of the Nation's children.

Brahm Fleisch

Foreword

In October 1989, the Alcohol, Drug Abuse, and Mental Health Administration sponsored a national conference on Treatment of Adolescents with Alcohol, Drug Abuse, and Mental (ADM) Health Problems. As the first conference convened under the newly formed block grant technical assistance program, this meeting brought together over a thousand practitioners and administrators working throughout the public and private sector treatment systems.

This Office for Treatment Improvement technical assistance publication evolved from a presentation by Dr. Brahm Fleisch at the adolescent treatment conference. This report reviews the impact of ADM disorders among the adolescent population, examines the research issues and treatment delivery system, identifies model modalities and programs to address the needs of adolescents, and makes practical recommendations on the implementation of effective treatment methods for youths.

I hope the information in this report helps to establish a framework and impetus for improving the services to our nation's most vital resource-- our children.

Beny J. Primm, M.D.
Associate Administrator for
Treatment Improvement

Executive Summary

With the dramatic increase in crack cocaine abuse in recent years, service providers around the Nation have become increasingly concerned about the growing population of adolescents with substance abuse and behavioral and emotional problems. For these young people the combined effects of mental illness and substance abuse is particularly devastating. Many of these multiproblem adolescents go unserved or underserved in the mental health and drug and alcohol treatment systems. Overtaxed rehabilitation programs for substance-abusing and chemically addicted adolescents are reluctant to admit young people with a history of mental illness. From the mental health perspective, some psychiatric and community mental health centers still screen out adolescents with substance abuse problems and refer them to other agencies. The net result of the reluctance or the inability of either system to treat mentally ill, substance-abusing adolescents is that they go "unclaimed" and untreated or undertreated.

Overview of the Study

The purpose of this report is to identify promising treatment approaches for adolescents with mental health and substance abuse problems. These approaches will be useful to programs, local service agencies, and States seeking to respond to the growing problem of substance-abusing, mentally ill adolescents. Special attention is paid to the range of services provided through the entire treatment process, from initial intake to aftercare.

In the first part of the report we set the context by examining the epidemiological evidence regarding the prevalence and incidence of substance abuse and mental illness in adolescents and by outlining the categories of programs in the drug and alcohol and mental health systems. In the second part of the report, we describe 12 adolescent treatment programs, selected for their unusual or innovative approaches or because they represent examples, according to State administrators, of "good" programs. The descriptions of the programs are based on telephone interviews and reviews of program literature conducted over a 2-month period. No site visits were conducted. While only one of the 12 programs requires formal dual diagnosis (e.g., drug dependency and major depression) for admission, all serve adolescents with mental health and substance abuse problems. The report concludes with general recommendations for the replication of innovative programs.

Major Findings

We found a variety of treatment strategies and approaches currently in use. Programs range from short-term school-based interventions to long-term residential therapeutic communities. Diverse approaches include programs that integrate legal, health, recreational, and educational services into treatment planning; programs that have developed culture-specific activities; and programs that make use of therapeutic foster parents. Although there are many differences in the services provided, there are also similarities: all of the programs offer some form of group therapy (i.e., peer counseling or self-help groups); many of the programs stress family involvement; all of the programs recognize that recovery is an ongoing process; and very few of the programs produce formal outcome data. Twelve programs are described in the report.

Clinic and Day Treatment Programs

School-based Strategy

Matrix Community Services in Tucson, Arizona, provides drug treatment and interventions in schools. This treatment approach provides alcohol and drug education, peer counseling, and alternative activities to effect schoolwide attitude changes.

Comprehensive Broad Services

The Door-A Center of Alternatives in New York City provides "one-stop" comprehensive services to adolescents in a youth center. Their approach stresses the need to

serve the whole person, with a range of services including legal, social work, health, educational, and mental health. The substance abuse and mental health component is integrated into an overall treatment plan.

Targeted Subpopulation

The Adolescent Female Treatment Group, located in a rural community in Oregon, provides counseling services to young women who have been sexually abused and are substance abusers. Receiving treatment for the sexual abuse concurrently with treatment for the addiction ensures that the young women are better able to remain drug and alcohol free.

Various Levels in Clinic and Partial Day Treatment

The Weekend Center, located in the suburbs of New York City, offers individualized treatment for adolescents at various levels of intensity ranging from a 10-week drug education outpatient program to partial day treatment 3 days a week. The treatment plan can be continually altered, depending on the individual's needs and treatment progress.

Culturally Specific Outpatient Treatment

Mainstream Youth Program in Portland, Oregon, is an innovative outpatient substance abuse treatment, education, and prevention program serving African-American youth from low-income families. Special emphasis is placed on community outreach and culturally specific approaches that address the particular needs of inner-city adolescents.

Residential Programs

Combined Day and Residential Treatment

Threshold for Change in Novato, California, is a comprehensive treatment program providing a range of services for a local community including day treatment and residential care. The program emphasizes case management through the entire treatment process, from assessment to after care.

Formally Dual-diagnosed

West Prep Adolescent Day Treatment Program in Valhalla, New York, is a unique program specifically designed to meet the needs of formally dual-diagnosed (mental illness and substance abuse) adolescents. The program combines a mental health day treatment model with substance abuse counseling, education, vocational training, and recreation in a year-long day treatment program.

Short-term Inpatient

Manor House of Portland, Connecticut, is a short-term inpatient program in a large child-and-adolescent psychiatric hospital. Adolescents are admitted to the inpatient partial hospitalization unit for between 7 and 45 days for stabilization and to begin recovery. After discharge, intensive day treatment and outpatient care are provided for a year or longer.

Day Treatment and Therapeutic Foster Care

Morrison Center in Portland, Oregon, serves drug-abusing, criminally involved adolescents in an innovative program that combines therapeutic foster care with day treatment. The adolescents move through three treatment phases, the final phase of which involves the return to the home and reintegration into local schools or jobs.

Therapeutic Community and Aftercare

Amity, Inc., in Tucson, Arizona, is a therapeutic community that provides substance abuse services to adolescents in the juvenile justice system. Adolescents begin the program while they are still institutionalized and continue through a therapeutic community setting and aftercare.

Long-term Residential and Transitional Apartments

Pahl House of Troy, New York, is an innovative, long-term residential program that includes a transitional residence for graduates of its therapeutic community. Some adolescents spend up to 2 years in therapeutic community and transitional apartments, maintaining continual contact with the staff as they become more independent.

State-level Initiative

The Alaska Youth Initiative in Juno, Alaska, coordinates services for difficult-to-serve adolescents. Interventions are varied and are based on the principle that treatment must be flexible, personalized, and as close to the youth's original community as possible.

Recommendations

The following recommendations are a synthesis of comments and perspectives from administrators, counselors, and clinicians interviewed while data were gathered on programs. Because little formal outcome data is available, these recommendations reflect the perspective of service providers based on their practical experience.

Project Design

Programs for chronic adolescent substance abusers should adopt a design that is intensive and long-term enough to ensure that changes are internalized. The length of treatment may vary according to the severity of adolescent's abuse problems, his or her mental health, and home and school environment.

Aftercare is a critical component. Although some adolescents do well in treatment, many relapse upon returning to the original environment. Strong transition and aftercare components can reduce the chance of relapse and help to ensure continuity of treatment goals. Specifically allocated funding streams should be made available.

HIV/AIDS education should be provided throughout the program. It must be geared to the adolescents' intellectual capacity and be culturally sensitive. Educational efforts focusing on AIDS must be coupled with strong, open-ended educational efforts focusing on the dynamics of relationships and the responsibilities associated with relationships.

Programs must address issues of culture and the economic realities of adolescents' lives. African-American and other ethnic communities have a tremendous need for services and the expertise of good treatment providers, but these providers must learn from the community how to deliver the service in a way that will be accepted. Ethnically diverse therapists must be hired and trained to serve as role models.

It is critical that all adolescents seeking treatment for substance abuse be assessed for a history of sexual, physical, and psychological abuse.

Therapeutic approaches should treat the whole person through comprehensive, integrated services that are easily accessible. A wide range of services and activities (special and vocational education, birth control services, recreational activities) enable adolescents to explore alternative lifestyles, engage in constructive relationships, and plan for independent, drug-free living.

Staff Training and Development

Staff who work with adolescents should undergo extensive and intensive training in family dynamics so that they do not inadvertently reproduce the dynamics of the codependent family.

All staff should receive cross field training. Substance abuse counselors should attend workshops on normal adolescent development as well as on mental health issues such as depression and anxiety, and mental health workers should have a clear understanding of the substance abuse field (e.g., enabling concepts) to encourage mutual respect and a clearer understanding of the dynamics of treating mentally ill, substance-abusing adolescents.

Work with Families

Many of these adolescents come from alcohol- and drug-dependent families. In general, the worse the home situation, the less effective the treatment, because addicted parents are often threatened by the recovery of a member of the family. Attempts must be made to provide interventions for parents who abuse drugs and alcohol.

Chapter 1—A Case History

Francisco is a 16-year-old Latino male from a socially stressed family and an economically devastated, drug-infested community. He lives with his maternal grandmother and uncle, both of whom are IV drug users. His mother is a heavy heroin and IV cocaine user who has been in prison at least twice for selling drugs. His father, whom he met only once in his life, is in prison for homicide. He has three younger siblings—a 14-year-old brother in a juvenile correctional facility in upstate New York and two other brothers, ages 5 and 6, who live either with his maternal grandmother or with his mother on the streets.

Francisco has a long arrest record. He was convicted on second-degree drug charges (selling) and grand larceny in a Bronx court and sentenced to a juvenile correctional facility. While in the state facility, he complained about swollen lymph glands. During the medical examination he was found to be HIV positive. In July 1988, the correctional facility returned him to the Bronx, where it was felt better treatment was available. He was discharged from the hospital 8 months later because of his abusive behavior and continued drug use.

Francisco reports consuming a gram of cocaine a day, either nasally in powder form or smoked as crack but denies using IV heroin or cocaine. He is a frequent user of marijuana, PCP, alcohol, and cigarettes. Francisco had his first sexual activity at the age of 10—it is unclear whether it was abuse or sexual exploration. By 13 he was engaging in street prostitution, often exchanging sex for drugs with male clients. At his most active he reports having seven to eight sexual partners a day in order to support his drug habit.

He dropped out of school in sixth grade, but has the reading ability of a third grader. He appears to have below-average intelligence. Actively suicidal, his five attempts, since 1987, have landed him in the hospital. On three of these occasions he left the hospital against medical advice; one hospital asked him to leave after he assaulted another patient. He displays violent behavior as well as self-destructive tendencies; for example, he recently mutilated his arm by scraping it with a broken bottle. He has very limited tolerance for frustration, is paranoid, and is very defensive. He has been clinically diagnosed as chemically dependent and conduct disordered, with underlying depression.

Long-term inpatient psychiatric treatment is the treatment of choice, but no consent can be obtained from the mother and he will not commit himself, so he continues to receive medical and mental health services on a crisis intervention basis only. Francisco's health is deteriorating. He is rapidly losing weight. Although aware that he is getting sicker, he is unable or unwilling to seek out consistent health care. His maternal grandmother is his major support person, but she has stopped giving him food and clothing because he sells them for drug money. His other major support person is a godfather who keeps in touch with him. He appears to be a friend of the family and someone that Francisco seems to trust. His grandmother does not speak English and has no telephone.[1]

Introduction

This report highlights innovative and promising treatment approaches for thousands of young people like Francisco. While Francisco's case is unusual in its severity and complexity, the problem of providing effective treatment for him is a microcosm of the challenge posed by the growing number of adolescents with serious emotional and drug and alcohol use disorders. The report highlights approaches that can be used by programs, local service agencies, and States seeking to respond to the growing problem of substance-abusing, mentally ill adolescents.[2] Special attention is paid to the issue of providing a continuum of services for these multiproblem young people.

The first part of the report examines the epidemiological evidence of the prevalence and incidence of substance abuse and mental illness in adolescents and outlines various treatment configurations in the substance

abuse and mental health system. In the second part of the report, we describe 12 adolescent treatment programs. Although only one requires formal dual-diagnosis (e.g., drug dependency and major depression) for admission, all serve adolescents with serious mental health and substance abuse problems. These programs were selected because they have unusual or innovative features (an integrated service approach, culture-specific activities, the use of therapeutic foster parents) or they represent good examples, according to State administrators, of a particular type of treatment program. The report concludes with a discussion of future research needs and provides general recommendations for the replication of innovative programs.

No site visits were conducted in the course of this study. It is likely that gaps exist between the programs as they are articulated on paper and their actual day-to-day functioning. To evaluate the efficacy of any program requires systematic and comprehensive research, a task that is beyond the scope of this study.

The Problem

The problems associated with the increasing numbers of adolescents with substance abuse and behavioral or emotional problems are gaining the attention of program administrators and policy makers. The growing population of troubled youth is most clearly evident in urban centers such as New York City. In 1988, 38 percent of adolescent psychiatric admissions to city hospitals were crack-related, up from 18 percent in 1987.[3] The combination of mental illness and substance abuse has a particularly devastating effect on the lives of these individuals. For example, substance-abusing schizophrenics are twice as likely to commit suicide as the abstinent person with the same diagnosis. The effects of the most recent wave of crack use has become a critical treatment issue for service providers, although its calamitous effects have not yet shown up in the clinical or epidemiologic research literature.

Although no systematic needs assessment has been conducted, anecdotal evidence suggests that many of these young people go unserved or underserved in mental health and drug and alcohol treatment systems. From a treatment perspective, the growing numbers of multiproblem adolescents are often faced with the prospect of very limited or fragmentary services. Overtaxed rehabilitation programs for substance-abusing and chemically addicted adolescents are reluctant to admit young people who require psychotropic medication to control their behavioral or emotional disorders. These programs often do not have the capacity to identify or address psychological problems. From the mental health side, some psychiatric and community mental health centers still screen out individuals with substance abuse problems and refer them to other agencies. From the standpoint of an addiction model, mental health professionals sometimes inadvertently "enable" the substance abuse when they view the substance abuse problem as a symptom of an underlying psychological disorder. The net result of the reluctance or the inability of either system to treat mentally ill, substance-abusing adolescents is that they go "unclaimed" and untreated or undertreated.[4]

An additional reason for focusing on this treatment challenge is the recent finding that many of the problems that mentally ill, chemically addicted adults experience first appear in the teenage years.[5] From the perspective of the adult mental health and substance abuse system, adolescent treatment is a form of prevention in which the young person can be stabilized, offered life skills and vocational training, and given access to the self-help community.

Epidemiological Evidence

Most teenagers use drugs or alcohol at some time, whether in experimental drinking, use of caffeine or cigarettes, or use of marijuana, cocaine, hard drugs, and prescription medications.[6] Although experts disagree about whether more or fewer adolescents are using illicit drugs, there is an emerging consensus that adolescents as a group are beginning to recognize the potentially harmful effects of hard drugs.[7] Further evidence of this consensus is reflected in statistics drawn from the National Institute on Drug Abuse's (NIDA) 1989 National High School Senior Survey. This study showed that drug use by high school seniors in the United States was at a 15-year low in the class of 1989. Current use (use in the 30 days before the survey) of cocaine by high school seniors decreased from 3.4 percent in 1988 to 2.8 percent in 1989. The proportion of seniors who had used cocaine at least once in their lives dropped from 12.1 percent in 1988 to 10.3 percent of the class of 1989. Current use of illicit drugs by high school seniors declined from 21.3 percent in 1988 to 19.7 percent in 1989; and annual use (use in the past year) declined from 38.5 percent in 1988 to 35.4 percent 1989 (U.S. Department of Health and Human Services, 1990).

However, reflecting another trend, one study notes that three out of four adolescents reported drinking regularly, and nearly 100,000 children between 10 and 11 years old reported getting drunk at least once a week.[8] This and other evidence suggests that a sizable subpopulation of our Nation's youth have serious enough drug

and alcohol abuse problems to warrant some form of treatment.

Prevalence of Substance Use and Other Psychiatric Disorders

What percentage of the adolescent population are alcohol or drug abusers and how many of these young people have other psychiatric disorders? Asked another way, what percentage of our mentally ill adolescent population are abusing alcohol or drugs? Although few specific studies have been undertaken to answer these questions, related research on drug and alcohol abuse and other psychiatric disorders can provide some clues.

A recent longitudinal study (ages 3 to 18) correlating illicit drug exposure with personality characteristics (Shedler and Block, 1990) compared frequent drug users, experimenters, and abstainers. Interestingly, the results showed that at age 18, experimenters were the best adjusted group. Compared to experimenters, frequent drug users were alienated, deficient in impulse control, and manifestly distressed; abstainers were anxious, emotionally constricted, and lacking in social skills.

In one "pre-crack" study, Beschner et al. (1985) estimated that 5 percent of teenagers aged 14 to 18 have substance abuse problems. In a 1985 study, Niven (1986) reported that 4.6 million adolescents (ages 14 to 17) had some problem identified as related to alcohol: arrest, involvement in an accident, or impairment of health or of job performance. Other preliminary data suggest that between 8 and 13 percent of late adolescents and young adults have alcohol abuse problems and 6 to 9 percent of them have other substance abuse problems. From the mental health perspective, the Institute of Medicine estimates that at least 7.5 million American children and adolescents have one or more mental disorders. This represents 12 percent of the Nation's population under the age of 18.

The findings from a number of recent studies suggest that the adolescent alcohol and other drug abusing population includes a high proportion of individuals with serious mental illnesses, many of which existed prior to the substance abuse problem. The other finding suggests that there is a very high incidence of psychopathology in polydrug users.[9]

Substance Use in Mental Health and Special Education Programs

Another way of approaching the problem is by examining substance use in specific settings where adolescents receive services for mental health problems. Two studies report that approximately half of all adolescents admitted to mental health facilities self-reported moderate or heavy drug and alcohol use.[10] Another study found the incidence of nicotine, alcohol, and other drug use to be considerably higher among students in classes for the emotionally disturbed than among students in regular education classes.[11]

Although there is growing evidence of the coexistence of mental health and alcohol and other drug abuse problems in adolescents, no consensus exists on the nature of the relationship between substance abuse and mental illness. The thoughtful analysis by Brown et al. (1989) of the problem as it pertains to the dual-diagnosed adult population is worth quoting in full:

> Although some researchers have suggested that there may be a causal relationship between use and abuse of drugs and/or alcohol and the development of chronic mental illness, this issue is far from settled. It is unclear whether some individuals are attempting to "self-medicate" their mental illness, whether substance use or abuse precipitates mental illness in certain vulnerable individuals, whether the same psychological or biological vulnerabilities underlie susceptibility to both mental illness and substance abuse, or whether a combination of mechanisms is involved. It is also possible that each of these hypotheses defines a subgroup of the dual-disordered population. (p. 566)

Irrespective of the etiology of these problems, it is clear that the coexisting problems must be acknowledged and planned for.

One final note on prevalence: various reports (see Plaut, 1989) make it clear that any research that was conducted before 1985, the beginning of the crack epidemic, has little relevance to the current situation, especially in urban centers.[12] The anecdotal information gathered through telephone interviews for this study suggests that there has been a meteoric rise in the numbers of mentally ill adolescents who are abusing or addicted to alcohol and other drugs. This situation is particularly clear in inner cities, among poor and working class youth.

Gaps in Research Knowledge

The epidemiological literature on the incidence and prevalence of alcohol and other drug abuse problems occurring with mental disorders is limited. A recent literature review (Community-Based Research, 1987) suggests that little is known about the problem and treatment of alcohol use among adolescents with handicapping conditions.

A pervasive problem with the current epidemiologic information is the absence of systematic and regular information about high-risk individuals, such as youngsters

who are not in school. Given the high dropout rate of seriously emotionally disturbed adolescents (between 41 and 50 percent), surveys of drug and alcohol use that focus on older cohorts of high school students may provide an overly optimistic view of the substance abuse problem. So too, data gathered in mental health and special education settings, while providing some information about the coexistence of substance abuse and mental health problems, underrepresent the number of young people in need of services because they exclude young people who have had little or no contact with the mental health or special education systems. This probably includes many youngsters who need services but have "fallen through the cracks."[13] Finally, the broader data collection systems often do not include adolescent populations. For example, data from the Epidemiological Catchment Area Program are of only limited value because the program's subjects are 18 years and older. Screening instruments that screen for the presence or absence of substance abuse and mental health problems must be developed to assess adolescents in an epidemiological survey.

Chapter 2—Setting the Context

To set the context for a discussion of the state of the art in treatment for adolescents with emotional and substance abuse problems, an outline of the configurations of services available in the adolescent mental health and substance abuse systems follows.

Adolescent Substance Abuse Service Delivery System

A variety of programs have emerged to serve the wide range of adolescent substance abuse needs. Different types of programs are designed for particular problems (type of drug(s) used, length and extent of use, personality traits, home and school environment circumstances). For clarity, programs have been divided into five categories as follows:[14]

Crisis Intervention Services

Crisis intervention programs have been established in some hospitals to treat individuals who have had serious or overdose reactions to drugs. Often referred to as "detoxification," this process may require stays of between a few days and several weeks. On completion of treatment, follow-up counseling is available and patients are referred for other types of treatment.

Inpatient Programs

Inpatient hospital programs provide both psychiatric and medical services. A typical inpatient program may include diagnosis of the severity of the adolescent's drug abuse problem; individual, group, and family counseling; and behavior modification. These programs are appropriate for adolescents with chronic psychiatric and drug abuse problems or medical and drug abuse problems. Although these inpatient programs are relatively brief, averaging 2 months, they are one of the most restrictive options, as many are located in locked wards.

Residential Treatment Programs

Residential chemical dependency programs are designed to remove the adolescent from the home and school environment where he or she uses drugs and to provide a new and healthy environment where young people can learn about themselves, the consequences of their behavior, and why and how to change drug behavior. Ranging from 2 to 12 months, these programs are less structured than therapeutic communities. Services provided may include individual and group counseling, self-help groups, educational activities, recreation, and drug education. Many try to include outdoor or wilderness experiences to foster self-esteem and cooperative behavior. Some offer aftercare and case management and require parental involvement.

Therapeutic communities are a highly structured, nonpermissive type of residential treatment. Most have daily regimens, including intensive encounter groups, group therapy, counseling, tutorial learning sessions, formal education, and residential job functions. The program is based on stages of recovery, each with a set of privileges attached. Adolescent programs last from 12 to 18 months.

Day Treatment Programs

Day treatment programs provide treatment for adolescents for more than 4 hours a day, usually between 5 and 7 days a week. These programs generally provide individual counseling, on-site self-help teen groups, group and family counseling, educational services including remedial education, vocational services, aftercare, and referral to other types of treatment where necessary. Recreational activities are often an important component of day treatment programs. The duration of the programs range from several months to 2 years.

Clinic Programs

Clinic programs provide a range of services, from unstructured drop-in centers to highly structured activities. Many of the services provided in day treatment are available on a less intensive level. Often these programs are affiliated with community mental health centers, YMCAs, or other private

organizations. Adolescents attend the programs one or more times a week, spending 1 to 3 hours at each session, for between a few months and 2 years.

Research on Substance Abuse Treatment Programs

Until a few years ago, when major governmental policy concern with drugs began, professional opinion held that true addiction was not a major problem in the adolescent population. But in recent years, private and public inpatient and outpatient hospitals and clinics have been established to treat adolescent substance abusers. For many acutely addicted adolescents, programs that include crisis intervention, detoxification, counseling and therapy, and self-help groups have helped them regain control of their lives.[15] Newcomb et al. (1989) offer the general observation that programs that involve the family in treatment and are designed to meet the developmental needs of adolescents are most successful. But despite the proliferation of programs, little is known about the effectiveness of different treatment approaches. The following summary of research focuses on the two most popular types of treatment: the therapeutic community and outpatient care.

Therapeutic Communities

In a comprehensive treatise on the therapeutic community, De Leon (1988) notes that the therapeutic objective is a total change in the patient's lifestyle, including abstinence from illicit substances, elimination of antisocial activity, employability, and prosocial attitudes and values. Until a few years ago, there were few residential drug programs specifically designed for adolescents. Many programs that served teens provided them with the same treatment as adult addicts, but service providers have begun to recognize that the two populations have very different needs. Adolescents have more family difficulties, are more likely to have psychological problems, and are more likely to have attempted suicide than their drug-addicted adult counterparts. State-of-the-art therapeutic communities for adolescents are beginning to restructure their programs to reflect these different developmental needs.

One report estimates that 11.4 percent of adolescent abusers are served in residential programs (Plaut, 1989). Another study, conducted prior to the recent increase in crack use, found that adolescents in residential programs were generally multiproblem youngsters with lower educational levels, more contact with the criminal justice system, previous treatment experience, and greater length and range of drug use than adolescents served in outpatient settings (Beschner et al., 1985).

Many therapeutic communities have high turnovers, especially of crack addicts (50 percent in the first 90 days). Approximately 85 percent of all adolescents admitted to therapeutic communities drop out before completion (De Leon, 1984). If a young person remains in the program for 6 months, his or her chances of eventual success are considerably better. Unfortunately, only a fraction of the substance-abusing adolescent population have access to or are able to complete a full therapeutic community program. Those who do have a significantly higher rate of employment and reduced rates of drug use and criminal activity, but these adolescents are generally the most motivated and most willing to acknowledge that they have drug abuse problems. The therapeutic community is frequently the placement of choice for youngsters addicted to crack,[16] but some cities report chronic shortages of beds in therapeutic communities.[17]

Clinic Programs

Clinic programs provide a variety of services including traditional psychotherapy and group and family therapy. Increasingly, these programs are incorporating 12-step meetings (Alcoholics Anonymous, Narcotics Anonymous, ALATEEN, etc.), recreational activities such as wilderness experiences, and tutoring or special education into their treatment approach. In a recent study of the characteristics of effective clinic programs, Friedman et al. (1985) found that these programs have certain common features. They have special schools or learning laboratories for school dropouts; provide special services such as vocational and educational counseling, recreational services, and birth control services; and use methods such as crisis intervention, Gestalt therapy, music and art therapy, and group confrontation. The authors of the study note that vocational counseling and school services within programs were most strongly related to positive treatment outcomes.

Family-based approaches appear to be more effective than traditional individual approaches with some adolescent substance abusers, especially younger adolescents. Plaut et al. (1989) cite a study in which 60 percent of adolescents in family therapy stopped drug use and an additional 12 percent reduced their drug use.[18] According to Plaut, the effectiveness of this approach is diminished because many adolescents do not have adequate family support to be able to fully utilize this type of treatment. Other research shows the long-term positive effect of the combination of problem-solving, communication training, and school conferences. Much research needs to be done to verify the clinical effectiveness,

cost-effectiveness, and accountability of adolescent drug treatment approaches.

Adolescent Mental Health Service Delivery System

There are four basic types of mental health services for adolescents. Not all of these services are commonly available.

Inpatient Programs

Acute care is for those adolescents who may be a danger to themselves or others, who need crisis stabilization, or who require short-term treatment and medical intervention. Acute care involves a comprehensive evaluation of the adolescent's and the family's clinical needs to develop a comprehensive treatment approach. Stay may range from a few to 30 days.

Intermediate care provides adolescents who have continued symptoms of serious emotional disturbance with treatment in a hospital setting. The aim of this care is to improve the patient's functioning in preparation for discharge. Stays range from 30 to 180 days.

Crisis intervention is based in hospital emergency rooms and aims to screen patients, reduce acute symptoms, and restore them to the precrisis level of functioning. Referrals are a key ingredient in the services offered during crisis intervention.

Residential Treatment Programs

Residential treatment facilities are less restrictive and less intensively staffed than hospital-based programs; they are more intensively staffed and provide a wider range of services than day treatment and clinic programs. These programs are designed for between six and eight children and provide structured daily living activities, problem-solving skills development, a behavior management system, and caring, consistent adult relationships.

Family care uses surrogate (professional) parents to maintain and treat adolescents in a home environment. In addition to the therapeutic effects of the surrogate family, adolescents may receive additional mental health services.

Partial Hospitalization Programs

Day treatment programs provide the most intensive nonresidential mental health services currently available. The programs blend mental health and special education services, including small classes for individualized instruction, individual and group counseling with parents, crisis intervention, interpersonal skills development, behavior modification, recreation, art, and music therapy. These programs are generally coordinated with or run by school district departments of special education.

Clinic Programs

Clinic programs aim to reduce the symptoms of psychological distress and improve the adolescent's functioning through active treatment. Services are provided in visits of less than 3 hours, usually 1 hour. The frequency, duration, type, and extent of services depend on the needs of the patient.

Vocational programs for older adolescents provide job skills training, including basic skills (cleanliness, punctuality, communication skills, ability to follow directions). Adolescents receive on-the-job supervision.

Case management provides continuity of care, appropriate service linkages, service planning, and monitoring for adolescents to maximize their ability to live at home and to receive necessary services in the community.

Research on Mental Health Treatment Programs

According to Burn and Taube (1989) there are large gaps in the literature on the effectiveness of different types of programs for mentally ill adolescents. Much of the research has focused on descriptions of service delivery systems, but very little is known about the outcomes of any of the systems.

Inpatient

In 1986, 115,783 adolescents were admitted to a hospital for a psychiatric condition.[19] Half of those admissions were to psychiatric wards of general hospitals, over a third to private psychiatric hospitals. Almost a third of those admitted were diagnosed with an affective disorder. Substance abuse accounted for 8.6 percent of adolescent admissions.[20] Although inpatient care is designed for the most severely disordered adolescents, few hospitals have specifically designated adolescent wards. Older adolescents are generally placed in adult wards and younger adolescents in children's wards. Although the research is limited, one report concluded that "the effectiveness of inpatient settings for adolescents offers caution about unnecessary use."[21]

Residential Treatment Programs

In the last decade, the number of residential treatment programs for mentally ill adolescents has increased dramatically, although these programs currently serve only a fraction of the population. Generally, residential treatment programs provide 24-hour care for emotionally disturbed adolescents with the additional feature of an on-site special school. They tend to

be freestanding institutions catering to high-risk (suicidal, psychotic, or explosive) adolescents. In 1986, 21,575 adolescents received mental health services in residential treatment centers. One study of the use of residential programs found that "to a great extent therapeutic treatment centers' use is often determined by whether there are workable family resources and whether intensive therapeutic services (home-based treatment, therapeutic group homes, or therapeutic foster care) are available in the community."[22] Concerns about the effectiveness of the treatment model, the restrictive nature of the placement (noncommunity setting), and the costliness of the services have been raised, although no systematic study has been conducted to evaluate these concerns.

Partial Hospitalization

Partial hospitalization/day treatment programs are designed for less severely ill adolescents. These programs use a mixture of traditional psychotherapeutic and rehabilitation approaches. Many partial hospitalization programs act as a bridge between full hospitalization and community or family living. Day treatment programs function as an alternative to inpatient care, where young people tend to spend 5 to 6 hours per day in the programs. Some programs provide a strong educational component and vocational training, as well as individual and group counseling and, in some cases, family intervention. According to Friedman et al. (1983) these programs are effective in maintaining students in their homes and produce improved academic and social functioning. Many programs report positive changes in the population served irrespective of their theoretical orientation. Burn et al. (1989) report on another study that found that 75 percent of the patients in a day treatment program were reintegrated into a regular school system.

Clinic Services

This group of services to adolescents incorporates a wide range of approaches and activities, such as psychodynamic therapy, behavioral modification, and supportive therapy. The activities range from brief 8-12-session procedures to multiyear approaches. In a recent review of the effectiveness of adolescent clinic treatment, Saxe et al. (1987) argue that "the average child receiving therapy was better off after treatment than two-thirds of control children, and the authors recommend that professionals not hesitate in defending child psychotherapy's merits."

Weithorn (1988) describes the few empirical studies that document the relative effectiveness of family-based and community-based treatment programs over inpatient care. These alternatives to residential care and hospitalization include such programs as Homebuilders Inc., which provides support and counseling to all family members and links parents with appropriate community resources.

Chapter 3—Treatment Programs for Adolescents with Emotional and Substance Abuse Problems

To provide an overview of innovative or unusual treatment approaches, as well the different types of program options, 12 treatment programs that have been identified as good programs by State authorities will be examined in some detail. Although the focus is on one aspect of each program, most of these treatment approaches have multiple services. For example, some programs offer day treatment and residential care, others offer partial day treatment and traditional clinic care. Only one of the 12 requires formal dual diagnosis (such as drug dependency and major depression) for admission, but all serve adolescents with serious mental health and substance abuse problems. We selected these programs because they have unusual or innovative features, such as an interdisciplinary service approach, culture-specific activities, and therapeutic foster parents. The programs are arranged from least to most restrictive in terms of setting, but the degree of restrictiveness has no relationship to the intensity or comprehensiveness of the treatment. Although the fees vary, with some programs providing services free of charge, all programs are committed to serving adolescents based on their need rather than their ability to pay. All the programs are at least partly funded by government agencies and many supplement this income with private fundraising and foundation grants.

Although there are many differences in the services provided, there are also similarities. All of the programs offer some form of group counseling—peer counseling, group therapy, self-help 12-step groups. To some extent, all of the programs offer individual therapy or counseling. Many stress family involvement. Like most adolescent treatment programs nationally, none of the 12 programs has been formally evaluated, and it is therefore not possible to determine their effectiveness.

School-based Intervention

Matrix Community Services

School- and Community-based Intervention Program
1030 North Fourth Avenue
Tucson, AZ 85705
Contact: Harry Kressler
(602) 884-7413

Case History: Fourteen-year-old Maria got drunk every day before school. She began to experiment with crack. On a few occasions she sold the drug to pay for her own use. Her teachers report that she does poorly in school when she attends. Her home life is very precarious. Her parents are divorced and her mother has multiple partners. Her mother moves the family every couple of months because of unpaid rent. Maria first learned of the Matrix services when one of the counselors gave a presentation in her English class and described the peer counseling groups that students could join. She has started going to the group session once a week. Her English teacher gives her an excused absence if she keeps up the work. This summer she hopes to participate in Matrix's summer program.

Program Philosophy: Matrix Community Services is an unusual school-based drug-intervention program in Tucson, Arizona, for adolescents facing multiple risks, such as parental substance abuse and low socioeconomic status. It is designed to offer adolescents the opportunity to build positive peer relationships that do not involve alcohol and other drugs. This is accomplished, in part, by making it possible for young people to become active participants in their communities. To encourage high-risk youth to mix freely with other young people, alternative recreational activities sponsored by Matrix are open to all students.

Population: Matrix serves minority, poor, and working class teenagers, 13 to 17 years of age, with histories of criminal behavior, sexual and physical abuse, emotional difficulties, and alcohol and other drug abuse problems. The 8 to 10 schools in the city serve as the primary intervention sites for the more than 300 teenagers in the program.

Program Description: The program consists of three distinct but interconnected components. Matrix Community Services begin with a

short-term substance abuse prevention curriculum that is delivered to middle and high school students in English, social studies, or health classes. The aim of the educational program is to provide students with information on drugs and to funnel them into the Matrix's intervention or alternative programs. During the 3- or 4-hour presentations, students are taught to assess peer and family relationships and patterns of substance abuse, and to reflect on their personal needs. After the presentations, Matrix counselors organize the students into youth-directed teams. A long-term prevention effort is Project Turnaround, funded by the U.S. Department of Education, in which 10 students from each school go on retreat to develop a drug-prevention plan or set of strategies to be implemented in their school environment.

The second component of Matrix—intervention—involves Matrix counselors' establishing and monitoring peer support groups in schools. Matrix counselors are at each school at least 1 day a week to help form the groups, which are conducted during school hours once or twice a week. Teachers must give permission for students to attend if the sessions conflict with students' class schedules. Over 50 percent of the students in the group sessions are self-referred. The group sessions have specific foci, for example, victims of sexual abuse, students with alcoholic parents, students with severe substance abuse problems and emotional difficulties. Young people come together to share their worries and use problem-solving techniques to confront everyday realities. In some schools, counselors co-facilitate groups with Matrix staff to provide on-site support for students. The counselors' role is to ensure that the sessions are helpful when students confront each other. Matrix counselors may begin the groups with their own stories, such as their experiences as recovered heroin addicts or dealing with having been sexually molested as a child. The counselors function as role models rather than as traditional therapists. The aim of the peer support group is to encourage teenagers to build healthy relationships with one another and ultimately to empower them to take control of their lives. These young people help each other in social problem-solving and in the process begin to build a good community environment.[23]

Once the adolescents are engaged in the group process, they are encouraged to become actively involved in the third component of the Matrix Services, alternative activities. Matrix organizes nontraditional programs to engage youngsters who generally don't participate in traditional recreation centers. These after-school activities have a dual purpose: to provide youth with a place to belong and to benefit the larger community with a purposeful project. During the past few years, youth in Matrix Alternative have worked with Teen Theatre, answering calls on Teen Talkline, on the Neighborhood Improvement Project (recycling and doing volunteer work that benefits the community), on publication of a teen magazine, on art education projects with music and pottery, and in wilderness experiences.

As an adjunct to their involvement in the interventions or in the alternative programs, students attend a 36-hour (minimum) retreat that focuses on personal history, family dynamics, commitment to maintaining a substance-free lifestyle and building positive peer relationships. Over the course of the last 14 years, Matrix has built strong working relations with school principals, teachers, and other district personnel.

Funding: The program is supported by grants from the City of Tucson, the State Health Services Agency, and Federal grants from the Department of Health and Human Services. They also receive donations and some income from services to other agencies such as the public schools.

Clinic Treatment

The Door—A Center of Alternatives

Comprehensive and Integrated Outpatient Services
121 Avenue of the Americas
New York, NY 10013
Contact: Julia Glover
(212) 941-9090

Case History: Lisa initially came to The Door when she was 16 years old. She had left home after a confrontation with her mother over her drug use and sexual behavior. She came to The Door for a VD test. During the initial intake interview, the counselors became aware of a number of other "unrelated" problems. She had no fixed abode, had dropped out of school, had no clear means of support, and appeared defiant and depressed. While living with a boyfriend she contributed to the household budget by selling drugs. Over the first few months of treatment, various professionals at The Door helped her with her medical, drug abuse, and emotional problems. Lisa agreed to meet with a drug counselor to explore her drug use. During the course of treatment, her drug counselor became her primary counselor, coordinating her use of other Door services and activities. Her mother was contacted by the program, but it was agreed that Lisa should not return home. She was referred to a group home but continued to participate in individual and group therapy at The Door. She began to take advantage of The Door's alternative school and became involved in dance and jewelry workshops. She came daily to The Door during the first 6-month period. After 6 months she decided to return to school, began to make visits to her

family, and eventually moved back home. She continued to use the services of The Door, including group therapy and the dance workshop. Even after graduating from high school and into the first years of nursing school, she used The Door's medical and career counseling services. She continues to keep in touch with her primary counselor.[24]

Program Philosophy: The concept behind The Door model is a service delivery system for teenagers that is at once comprehensive and integrated, meeting the needs of the whole person. The center's one-stop service delivery system provides a range of services staffed by physicians, mental health workers, nurses, family planning counselors, health educators, nutritionists, lawyers, social workers, artists, and physical education specialists. The elements are interconnected; for example, the recreational activities are understood as integral parts of the overall wellness of the adolescents. Teenagers can receive or participate in any combination of services and activities. The goal of the intensive program is to help them achieve psychological well-being and give up addictive substances and the associated lifestyle.

Population: The Door is open to all teenagers from 12 to 21. Most youngsters who use the services come from impoverished neighborhoods in New York City. Nearly 50 percent are not living at home, almost half have dropped out of school, and 28 percent have no regular means of support. The Door also has developed an intensive program for young people who are struggling with depressive reactions, suicidal behavior, and alcohol and other drug abuse. Adolescents initially come to the program to use a variety of the services offered, especially the crisis intervention, the free medical clinic, and the recreational facilities.

Program Description: The Door—A Center of Alternatives is a multiservice, patient-centered youth program. Services include programs for pregnant teens, teen parents and their children, a free meal program, social services, crisis intervention, homeless and runaway counseling, mental health counseling and therapy programs, drug and alcohol treatment, education programs (basic literacy classes, structured stay-in-school programs, tutoring, English as a second language instruction, preparation for GED, college preparation programs), career counseling, on-site vocational training, and job placement. The center also provides legal advice and advocacy, and creative arts, including performing arts (theater, music, dance); physical arts (sports, martial arts, physical fitness); and visual arts (photography, sculpture, pottery, silkscreen, jewelry, and fine arts).

The idea is to move from dealing with the young person's initial problem or interest to facilitating an ongoing involvement in more intensive treatment. Drug counselors continually do workshops in all the recreational programs offered at The Door. A young person who entered the program to take karate classes, for example, may later be willing to reveal that he or she has a problem with drugs, has had trouble with the law, or suffers from depression. The youngster would then move into drug counseling, involving group meetings a couple of nights a week and appropriate individual counseling. The supportive, nonthreatening atmosphere provides the space for adolescents to break down their denial and other defenses at a pace that is manageable for them.

Admission and Intake: Before admission, the young people go through an intake screening with counselors to work out a plan that may include services such as emergency housing, legal services, and temporary employment for youth in crisis. The intake screening includes questions about medical needs, psychiatric problems, drug use, family history, schooling, legal issues, potential strengths, and many other areas of the adolescent's life. A primary counselor is assigned to each young person to ensure continuity and quality of care. This counselor serves as the young person's mentor and advocate, helping to plan his or her use of the program and attempting to resolve conflicts in other areas such as school, family, and the courts. Together they develop a treatment plan appropriate to the teenager's particular life history, related psychosocial problems, and behavioral difficulties.

Drug and Alcohol Treatment: The intensive program consists of four phases, moving from stabilization to autonomy. During Phase I, the teenager is stabilized and problems associated with the crisis-oriented lifestyle are resolved. In Phase II, the adolescent builds up inner strength and self-awareness in individual and group sessions. Anger, stress, and other feelings and conflicts behind their life difficulties are dealt with. Reintegration and exploration of alternatives are the thrust of Phase III. The young people are encouraged to explore new values and attitudes and are provided the space to express these changes in constructive interpersonal and social terms in recreational, educational, and career activities and workshops. The final stage, Phase IV, is designed to help young people to assume full responsibility for their lives and to make decisions regarding life directions, for example, by providing job placement options.

Throughout these stages of treatment, adolescents may make use of a variety of therapeutic approaches and other services. Individual therapy allows teenagers to explore their anxieties, positive

and negative experiences, and perceptions of reality. Group therapy provides a supportive and challenging peer environment in which young people can begin to work through problems of interacting and relating to the world outside. The groups explore common themes such as isolation, insecurity, and substance abuse. Young people help each other to understand and break down common defense patterns (denial) and discuss and share solutions to common problems. What makes The Door's program unique is the on-site availability of social work, legal, educational, and vocational services that allow the young person to deal with the functional realities of life while working through psychological and substance abuse problems.

Positive Youth Culture: The program recognizes that a positive youth culture needs to be fostered to offer an alternative to street and gang culture. The adolescents who use the services and activities of The Door do not perceive themselves as "patients" or "high-risk youth" because the services are open to all. Troubled teens interact with relatively healthy other young people during vocational and recreational activities such as the popular Young People's Performing Arts Company, a gospel ensemble, and gymnastics. These activities and workshops are integral to The Door's therapeutic approach: by offering these special activities, the center is able to work more effectively with young people, dealing with the totality of the life experience rather than providing isolated care for specific needs. Many of the workshops and recreational activities are staffed by volunteers and artists-in-residence who make use of The Door space during the morning in exchange for services rendered in the afternoon and early evening.

Links to Other Agencies: The Door has extensive links with many of New York City's youth-related agencies and institutions. These include interagency liaisons, referral, and back-up arrangements with schools, hospitals, health and mental health facilities, social services agencies, churches, courts, legal aid agencies, residences for adolescents, and residential drug and alcohol treatment programs.

Funding: The Door's services are funded through a variety of channels. For example, the center receives a State grant for drug prevention and treatment services. Special emphasis is placed on obtaining support from the private sector—foundations, corporations, and individuals—to allow for greater program flexibility. According to one of their brochures, "The Door reduces the long-term cost otherwise incurred when health, mental health, and social problems go unresolved and require long-term intervention including institutionalization and other costly forms of public assistance."[25]

Replication and Outcome Data: The Door model has been replicated in a number of places in the United States. Although these programs may have different components, they share the concept of the whole person approach, comprehensiveness, complete services, multiple activities under one roof, and extensive links with other services in the community. In Washington, D.C , the Center for Youth Services shares a common philosophy with The Door and has received technical assistance and training from The Door staff since its inception. One serious barrier that hampers the replication of this model is the narrowness of many of the funding streams that restrict the kinds of services and activities that can be provided under the rubric of the grant. The Door has been able to work around this problem to some degree with funds from nongovernment sources, i.e., private foundation and corporate support.

Beschner et al. (1985) report on an evaluation that was conducted on The Door's Learning Laboratory for adolescent substance abusers. The evaluation found positive changes in education, drug use, and involvement in purposeful activities.

Adolescent Female Treatment Group: Deschutes County Mental Health

Outpatient Treatment for Sexually Abused, Substance-Abusing Adolescent Females
409 NE Greenwood
Bend, OR 97701
Contact: Thomas Olson
(503) 388-6601

Case History: Alison, who is 16, comes from a poor, rural part of Oregon. She reports having been sexually abused by her father at the age of 8. In her early teen years, she became a prostitute at about the time she began drinking regularly. She has a history of academic problems in school and frequently runs away from home. At 13 she was arrested on charges of being a minor in possession of drugs. She was referred by the judge to the Deschutes County Mental Health Clinic for drug and alcohol treatment.

Program Philosophy: What makes the Adolescent Female Treatment Group unusual is its recognition that many young women referred as substance abusers have been sexually abused. Traditional substance abuse programs that serve these female adolescents focus their therapeutic work on the substance abuse or chemical dependency, assuming that other problems, such as self-harming behavior, can only be addressed after a lengthy period of sobriety. Addiction treatment approaches contend that any continued substance use would interfere with mental health treatment. However, in the process of working with sexually abused young women

who abuse drugs or alcohol, the mental health workers at the Adolescent Female Treatment Group found that if the sexual abuse issues are not addressed concurrently, the young women had difficulty remaining drug and alcohol free. They found that sexual abuse issues must be treated at the same time as the substance abuse problems.

Population: The Adolescent Female Treatment Group serves a particularly troubled population of substance-abusing adolescent females between the ages of 14 and 18 who have been sexually abused. The young women served in the program come from low-income families, approximately 80 percent of whom are on public assistance. Most of the families are headed by a single parent who is a drug and/or alcohol abuser. Over half of the adolescents currently reside in a county group home where they have been placed by the courts. In order to receive services they must have a DSM III diagnosis of either substance abuse or chemical dependency. In addition, most have a second independent diagnosis such as conduct disorder or post-traumatic stress syndrome. A few have had contact with the mental health system through local hospitals for crisis intervention, but for many, the Adolescent Female Treatment Group is their first experience with any kind of mental health treatment. The program does not admit teenagers on psychotropic medication.

Program Description: The program currently serves six teenagers in group therapy once a week. The program has a family counseling component that meets at least once a month. Along with group therapy, the treatment includes education and development of social skills to deal with the complex issues raised by being a victim of sexual abuse and a substance abuser.

Admission and Intake: The clinic gets most of its referrals from two agencies. Social Services refers young women in danger of being removed from their home and those who have already been removed. In many cases these young women have come into the system as a result of their having been sexually abused. The other type of referral comes from the courts, where young women have been brought before the judge for alcohol- and drug-related problems. During intake, the clinicians screen all young people for possible sexual abuse and drug and alcohol abuse. Those young women who have both problems are referred to the Adolescent Female Treatment Group. Almost all of the members of the group have serious drug and alcohol abuse problems that began before their teenage years. Other problems include histories of sexually promiscuous behavior, multiple suicide attempts, and self-mutilation.

Drug and Alcohol Treatment: The Treatment Group meets once a week for one and a half hours. During the session young women discuss relapse issues and urges to run away and do problem-solving associated with their daily problems.

Funding: Some of the young women's treatment slots are paid for by State Mental Health funds, others by State Alcohol and Substance Abuse funds.

Partial Day Treatment

The Weekend Center

A Clinic and Partial Day Treatment Program
666 Lexington Avenue
Mt. Kisco, NY 10549
Contact: Janet Eldon
(914) 666-6740

Case History: Aaron had been seeing a psychologist for 6 months, but his parents noticed more and more signs of drug use. He had withdrawn even more from the family. When he was at home, he isolated himself in his room, refusing to engage members of the family in conversation. One night his parents got a call from the police station. Aaron had been picked up for driving while intoxicated (DWI).

Program Philosophy: The Weekend Center's adolescent program is designed to provide individualized treatment for troubled adolescents. For teenagers who are getting into trouble for the first time with alcohol and other drug use, the Weekend Center offers a 10-week program that focuses primarily on drug education. If the problem has become more serious and the teenager has associated emotional problems, individual therapy and a 12-step program are recommended. If the young person has serious substance abuse problems, the program has developed an intensive partial-day treatment program.

Population: The Weekend Center, located in the suburbs of New York City, serves adolescents from 14 to 18 years of age in an outpatient clinical setting. The majority of the youngsters served are white males from middle- and upper-middle-class families. Approximately 70 percent come from families in which at least one adult is a problem drug or alcohol user. Although the center is primarily designed for drug and alcohol treatment, many of the young people who use its services have secondary psychiatric diagnoses ranging from conduct disorder to depression. The program does not exclude young people on psychotropic medication, but it has not served anyone with a major psychiatric diagnosis. The youngsters' drug use may be as limited as weekend binges or as extensive as daily use of cocaine, alcohol, and marijuana. These adolescents began experimenting with alcohol or other substances when they were as young as 9 years old. Many have been in some form of traditional psychotherapy that

proved to be unsuccessful. The program also serves adolescents who have received inpatient treatment and have returned to their communities.

Program Description: The Weekend Center receives referrals from parents, school student assistance teams, clergy, juvenile courts, local mental health workers and self-help groups, intensive inpatient treatment centers, and some self-referrals.

Admission and Intake: The intake assessment, which involves both parents and teenagers, is designed to evaluate how willing the youngster is to work toward recovery. The assessment explores the level of drug use, legal problems, blackouts, histories of sexual and physical abuse, family systems, and related psychological problems. If the director sees the need, the youngster is referred to a more intensive setting or, if there is any medical danger associated with withdrawal, to a detoxification center.

Drug and Alcohol Treatment: The program is designed to allow for a great deal of flexibility in treatment. For adolescents with limited problems with drug or alcohol use, the Weekend Center offers a 10-week program that focuses primarily on drug education. If a problem has become more acute and includes associated emotional problems, the treatment plan may involve individual therapy and a 12-step self-help group. If the young person has very serious substance abuse problems, the program has developed an intensive partial-day treatment program. The adolescent at this level attends the program 3 days a week from 3:00 to 7:00 pm. During these 4 hours, the young person spends an hour in group therapy. There is an individual session once a week with the primary therapist. The adolescent also participates in art therapy, recreational activities, and alcohol and other drug education. The program provides dinner. After 9 to 12 months, the adolescents gradually reduce the number of days in the program from 3 to 2 to 1, until they are in individual therapy for an hour a week. This treatment can continue as long as it is needed. During the partial-day treatment program, parents are required to attend a family session once a month, as well as a parent support group once a week.

Relations with Other Agencies: The outreach staff at the Weekend Center have developed a strong working relationship with community professionals with whom they do outreach educational programs on drug and alcohol abuse. They work closely with student assistance counselors who often refer adolescents for treatment. They also have developed relationships with the staff of local inpatient treatment programs. The program also provides aftercare services for adolescents who have completed intensive inpatient treatment. The continuum from individual therapy to partial-day treatment works for youngsters returning to families and schools where they will encounter alcohol and other drug problems. It offers a supportive environment when supplemented by regular attendance at 12-step program meetings.

Funding: The program is partially funded by New York State Alcohol and Alcohol Abuse Services and the Task Force for Integrated Programs.[26] This State grant covers about 75 percent of the cost of the program. Additional funds come from private fees and third-party payers.

Mainstream Youth Programs, Inc.

African-American Outpatient
5311 S. E. Powell Blvd.
Portland, OR 97206
Contact: Kathleen Himsl
(503) 777-4141

Case History: Wayne has lived in public housing projects all of his 14 years. Since his mother left him and his two younger sisters at his grandmother's apartment 6 years ago, he not has seen or heard from her. His grandmother has tried hard to keep all of the children clothed and fed. A few years ago he began hanging out with some kids in the building. At first they just drank and smoked marijuana, but later he began to make money selling cocaine. He came and went as he pleased. He hasn't been in school in 3 months. Although he has had contact with the police and the social worker from Children's Services, they'll probably leave him in his grandmother's custody without any special assistance until he does something "serious." He came to Mainstream because a friend was going there to play basketball. He now attends irregularly, not having made a firm commitment to recovery. He comes because he likes to play basketball with the counselors and to hear them talk about African-American history and culture. He is curious about these men who are clean and sober, living a lifestyle with which he is unacquainted.

Program Philosophy: Mainstream Youth Program is an outpatient adolescent substance abuse treatment, education, and prevention program. What makes Mainstream's treatment program for African-American adolescents unique is its insistence that the recovery process must be viewed as a cultural event. The program's role goes beyond the treatment session. The staff have become part of the community—their office is located in the heart of the community that they serve and they are available to help the community to find solutions to its problems.

Population: Mainstream serves African-Americans and other ethnic minority youth, aged 12 to 18, from low-income families in Portland, Oregon. Eighty percent of the young people are African-Americans living in a public housing project. Seventy percent

are male, 90 percent come from homes on public assistance, and 75 percent live with adults who are themselves alcohol or other drug abusers. Many of them have had contact with juvenile justice. Many are enrolled in alternative high schools and live in group or foster homes. Living in poverty, many of these young people have not been exposed to alternative traditions within their own culture. They have strong bonds with their peer group, where loyalty is the raison d'etre. Substance use is a taken-for-granted aspect of their daily lives. For many, drugs are far more than mind-altering substances; they play a key role in these teenagers' social and economic survival.

Program Description: When Mainstream first opened in the neighborhood, its services frequently went unused in an area where drug abuse was an overwhelming problem. The staff found that they needed to make their services culturally specific to respond to the particular alcohol and other drug treatment needs of these adolescents and their community. Informal networks were established as a way of attracting youth Mainstream collaborated with local community groups such as, the Youth Gang Task Force on "prevention teams" to develop strategies to reduce the negative presence of drugs in the neighborhood. The staff of the center now serve as strong role models and are present at community activities, schools, and neighborhood gatherings and events to make a drug-free presence felt in the community.

Admission and Intake: The clinic services begin with a traditional intake evaluation. During the interview, the clinician explores the various family and other supports the young person might have, school history, behavioral patterns, level of functioning, and coping mechanisms. All the information is checked with family members, the schools, social workers and other members of the community. The clinician focuses considerable attention on alcohol and other drug use, to understand how the drug use is tied to the economic reality of the young person's life. For example, in some cases, money from the sale of drugs provides the family with its major means of support. Unlike sobriety in middle-class communities, for many of the young people served in the Mainstream program, being clean and sober means a decline in their economic and social status.

Drug and Alcohol Treatment: Adolescents who are accepted into the program attend group and individual sessions after school, 2 to 3 days a week for 2 hours a day. Where possible, family sessions are integrated into the treatment program. Regular urine analyses are conducted. While the youngsters are in the program they become involved in community drug-free activities. Recently they played an active role in making a local drug-free video commercial. The young people become part of the drug-free presence in the community.

The program is open-ended. Some youngsters have been in the program for over a year. Other young people come to the program but are unsuccessful and are referred to residential treatment. After the young person completes the inpatient program, Mainstream may function as an aftercare program, offering a supportive drug-free environment.

Mainstream counselors spend time in the local junior, senior, and alternative schools where they have a high profile. Integral to the therapeutic approach is the use of former addicts as counselors who share the same cultural heritage as the teenagers. They function as role models, not just for the youth in the program, but for all the children in the community. In this sense the program blurs the line between prevention and treatment.

Funding: Mainstream offers all of its services free of charge. It is funded by the local Youth Program Office, the County Juvenile Service Committee, and through a grant from the State Alcohol and Drug Programs Office. The monies are allocated both for treatment and prevention.

Day Treatment

Threshold for Change

Residential Day Treatment Continuum
619 Canyon Rd.
Novato, CA 94947
Contact: Leslie Acoca
(415) 898-3316 or (415) 488-4647

Case History: Tom is a white teenager who lived with his mother. His father has been in and out of prison on a string of drunk driving convictions. At 16, Tom was arrested for robbery. He was caught taking stereos to support his cocaine habit. He was originally referred to Threshold by his probation officer, who saw it as a less restrictive alternative to the county juvenile correctional facility. He came to the day treatment program from 8:30 am to 4:30 pm, 5 1/2 days a week. Sunday was family day at the program. Two nights a week, his mother came for multiple family group sessions. After a few months of the program, he slipped out and went to a local crack house. He was discovered and transferred from the day treatment program to the residential program because it was felt that he needed a more intensive level of treatment. Most adolescents take 6 months to work through the residential program. It took Tom 9 months. His mother, who is a drug user, was threatened by his recovery. During the course of her participation in the program, she has been able to sustain sobriety for a few months. If his mother's sobriety continues he will be able to return home after he graduates from the program.

Program Philosophy: Threshold for Change is a comprehensive treatment program serving adolescents with serious alcohol and other substance abuse problems. It is specifically designed to treat troubled youth from low- and moderate-income families in their own community. Before the establishment of the program, Marin County had only a few programs serving adolescents. These programs tended to exclude youngsters in need of treatment because of their prohibitive costs. Developed to respond to this need, Threshold offers a continuum of services for local youth, including day and residential treatment and aftercare. An independent living component will be added in 1991. At present Threshold identifies foster homes for those adolescents who have completed the program but cannot return to their families.

Population: The program serves boys and girls age 13 to 18. (They expect to open day treatment services for 8- to 12-year-olds in 1991.) Although the county Threshold serves is 12 to 15 percent minority, minority adolescents make up 20 to 60 percent of the participants in this program. Most come from substance-abusing or chemically dependent families, many with a single parent and a low income. Many of the families have histories of child abuse and numerous contacts with the criminal justice system.

All of the adolescents served have a substance abuse or chemical dependency DSM-III diagnosis. In addition to these diagnoses, many of the adolescents have other psychological diagnoses. Most of the young people are developmentally delayed because of substance abuse and function at the social and emotional level of 12-year-olds. The director estimates that about 90 percent of the teenagers served in the program have experienced physical, psychological, or sexual abuse during their childhood. Many of these adolescents are at high risk of contacting AIDS because of their sexual and drug use behaviors. All of the young people served are polydrug abusers, with alcohol, marijuana, and cocaine most commonly used. Most began experimenting with drugs between the ages of 5 and 11. In the first group of teenagers in the residential component of the program, 60 percent of the adolescents were IV drug users. During the past year, the program has seen an increase in the number of youngsters referred who are using crack.

Program Description: Threshold has developed a strong working relationship with public referring agencies such as the juvenile justice system, the schools, and social service agencies. They found it helpful to have one person in each referring agency designated as a liaison with the program. This person has a strong working relationship with the program director and coordinator and a thorough understanding of the operation of the treatment program. Once an adolescent is referred, Threshold conducts a screening that is designed to assess how motivated the youngster is to recover. Each young person is assigned a Threshold case manager, who plays a central role in overseeing the entire referral, treatment, and aftercare service process. Threshold is able to maintain high-quality case management by using funds from private donations and foundation support to provide the extra time for long-term planning and follow-through with each young person. The case manager also visits the adolescent's home if possible and networks with the teen's local school.

The initial evaluation phase may take several days. Included in this process is a home visit to determine the nature of the adolescent's substance abuse problem and the possibility of substance abuse among other members of the family or close friends. This determination is important because untreated substance abuse in the family may lead to the adolescent's relapse. The case manager uses the home visit to develop an understanding of the family system and to do case planning. The process of involving the family has a dual function. First, it enables the case manager to understand how the family system works, and second, it allows him or her to do on-site substance abuse education. The case manager might do in-home interventions or refer young persons to day treatment or, in more severe cases, to the residential program. Assessment of the young person and the family allows the case manager to determine the severity of the problem and to choose the appropriate level of treatment.

Drug and Alcohol Treatment: The day treatment component offers a structured, intensive program, including school, recreation, physical fitness, recovery groups, and other planned activities. In addition to serving community youth, the day treatment component is part of the continuum of care for adolescents making the transition from residential treatment back into their homes or into foster care. The emphasis in the day treatment school is on basic skills in English, math, science, and social studies. Because many of the students have academic problems, their learning abilities are assessed so that instruction can be individualized in the small classes. The curriculum also includes a weekly life-skills class with a unit on sex and AIDS education. For those students not returning to school, tutoring for the GED is provided by the teacher. The classroom teacher is provided through an agreement with the county office of education. The school component is an integral part of the treatment approach; these young people build self-esteem when they become

successful learners. The after-school hours are filled with recreation activities, physical exercise, group meetings, and quiet time. In addition to the regular school curriculum, the Threshold school includes a course on chemical dependency. The class introduces students to the concept of chemical dependency as a disease, explains its effects, and acquaints them with the 12-step program for recovery.

For young people in need of intensive treatment, Threshold has established a residential treatment component. During the first 5 days in the residential program, the youngster undergoes a detailed assessment, including a review of all patient and family records, evaluation of adolescent and family chemical dependency, psychological testing, a medical examination, and social history. After a month or longer in residential treatment, the case manager and the adolescent develop a long-range recovery and treatment plan, which may include reunification with the family or assisted independent living.

While in residence, the youngsters attend the day treatment program. This allows them to make contact with other young people who are in more advanced stages of recovery. The adolescents in the residential program attend at least 3 12-step program meetings a week, as well as daily meetings with their peers in the residence. Recreational activities in the residence include special day trips and longer wilderness experiences. There are family sessions once a week at which the clinician uses an intensive family systems approach to recovery. The families also attend ALANON meetings, family education and support group, and family therapy sessions. Many of the young people have the option of continuing in the day treatment component while living at home or with foster parents.

In addition to the residential component and the day treatment center, Threshold has developed a number of other services as part of the continuum-of-care system. These include therapeutic foster homes, job apprenticeships for older adolescents who have moved through the early stages of recovery, and assisted independent living for adolescents 17 and older who are unable to remain or return home from a residential setting.

Funding: Threshold supports this continuum of care from 12 different funding sources. Primary support comes from State and local public agencies, with significant contributions from foundations and local corporations. A small part of the funding comes out of a grant from the State Alcohol and Drug Abuse Agency, with additional funding from adolescents referred by the juvenile justice system, social services, and mental health. The residential and foster care components are funded under Aid to Families with Dependent Children. The local school district provides the educational services.

West Prep Adolescent Day Treatment Program

Day Treatment for Formally Dual-diagnosed Adolescents

Westchester County Medical Center
P.I. West Prep Program
Valhalla, NY 10595
Contact: Steven Schwabish
(914) 285-7281

Case History: Charlie is a 16-year-old who has a history of self-mutilation and heavy alcohol and cocaine abuse. He has treatment failures in both the substance abuse and mental health systems. On one occasion, he cut words into his skin and put cigarettes out on himself. His father is a construction worker. His mother, who works part-time in a department store, has an alcohol abuse problem, as does his older brother. Charlie is on Trilaton to control his depressive episodes while he works toward sobriety. His parents have become actively involved in parent education and support groups.

Program Philosophy: West Prep Adolescent Treatment Program is unique in its focus on the dual-diagnosed adolescent population. Although the treatment of chronic substance-abusing young adults has become a focus of concern, we found few programs in the course of this study that have developed specific treatment approaches that integrate aspects of the addiction model into the framework of adolescent mental health treatment. This program is noteworthy in its ready inclusion of young people who need psychotropic medication to stabilize and function.

Population: The West Prep Adolescent Treatment Program serves young people, ages 14 to 18, who are suffering from both a mental illness and chemical dependency. Most of the youngsters have been unsuccessful in other treatment environments, such as private for-profit residential treatment programs and individual psychotherapy. West Prep, located in the New York City metropolitan area, serves adolescents from a range of economic backgrounds, although the majority are white and male. The young people's families are generally functional. One-third come from single-parent households.

The youngsters who are admitted to the program are required to have a freestanding major psychiatric diagnosis (bipolar psychotic disorder, preschizophreniform type disorder, oppositional disorder). Most come to the program with serious learning disabilities. Over half have been hospitalized in either a psychiatric hospital or an inpatient substance abuse program. All are polydrug users. One teen reported using up to 10 vials of crack a day. Many report drinking until they black out. West Prep excludes IV drug users but refers

them for more intensive inpatient treatment.

Program Description: Young people are typically referred to West Prep by school guidance counselors, parents, and psychiatric hospitals. A number have been referred as the result of special education evaluations. Others are referred by residential treatment centers as part of their aftercare programs.

During the intake process, the adolescent is assessed by a clinical social worker, a psychiatrist, a substance abuse counselor, and a psychologist. Within the first week, the team evaluates the extent of the chemical addiction and the mental illness and develops an initial 30-day treatment plan. During this period, the team plans a comprehensive 3-month treatment plan. The aim of the treatment plan is to move the young person toward sobriety, stabilize the psychiatric disorder (with medication if necessary), and involve the family in the process of recovery.

Treatment Approach: West Prep requires a minimum of a full-year commitment to the day treatment component. The day treatment is open from 9:00 am to 3:00 pm, the major part of the day being spent in studying math, science, English, and social studies. Substance abuse education is integrated into the social studies curriculum through study of the family system and issues of codependency. In science, the youngsters study the chemical aspects of alcohol and other drug use and human biology.

In addition to the academic subjects, the young people attend an individual counseling session, a group therapy session, daily group meetings, regular 12-step meetings, and psychodrama groups. Approximately 12 hours a week are spent in some form of therapeutic experience. The psychiatrists evaluate the medication needs of each adolescent and prescribe, when necessary. Vocational and recreational activities are provided for through the use of the local Board of Cooperative Educational Services program. A significant aspect of the work of West Prep is crisis intervention. The social worker often works directly with the young person and his or her family in the home to resolve particular crises. The families participate in weekly family therapy sessions and biweekly education and support groups.

If, after a year in the day treatment program, the case manager and the planning team are satisfied that the youth has been stabilized and is actively working in the 12-step program, he or she returns to school. For the next 3 to 6 months, the young person will continue to see the individual therapist and continue with group sessions. The family component also continues during the exiting phase.

Family Participation: Parent and family participation is a crucial element in the success of the program. Without the cooperation of families, and sometimes intervention in the family system, many of the youngsters will relapse into previous behaviors. The program's philosophy is that these adolescents have two freestanding problems that must be treated concurrently. West Prep does not expect total sobriety from the moment the young person enters the program; rather, it is a goal toward which to work.[27]

Funding: The program, which is affiliated with the county medical hospital, is funded by a grant from the New York State Task Force on Integrated Programs. There is a sliding-scale fee for services, and private insurance and Medicaid are accepted. No person is refused services because of inability to pay. The county provides space for the program free of charge. The local school district pays for the educational component.

Short-term Inpatient

Manor House at Elmcrest and Manor House at Elmcrest Partial Hospital Program

Short-term Hospitalization
25 Marlborough Street
Portland, CT 06480
Contact: Mary K. O'Sullivan-Evans
(203) 342-0480

Case History: Jason is a 17-year-old from a middle-class suburban town. His parents and teachers began to notice changes in his behavior about a year ago. He slipped from being a B student to failing all his high school courses. He began to stay out late at night and, when he was at home, he either isolated himself or acted out. His father found drug paraphernalia, but when confronted, Jason denied that it was his, first denying any knowledge, then saying that he was keeping it for a friend. He lost his after-school job and was unable to keep others. Over the year, he became increasingly isolated and aggressive at home. Finally, his mother found that money that was kept in the family safe was gone. His parents gave him two options: get treatment or leave home.

Program Philosophy: The Manor House program is unusual in three respects. First, as part of a large child and adolescent psychiatric facility, the program has immediate access to medical and nursing services, a sophisticated biofeedback clinic, and immediate access to more secure settings for adolescents who are dangerous to themselves or others. Second, Manor House offers a continuum of care ranging from intensive inpatient to outpatient therapy. Finally, the program is noteworthy in that it offers young adults 18 to 22 a special program that includes a strong vocational assessment and training component.

Population: The adolescents treated in the program range from 13 to 22 years of age. The older patients, those 18 to 22, are served in a program specially designed for young adults (not described here). The younger population is predominantly male and racially mixed, with 50 percent white and 50 percent African-American and Latino. The young people come from a variety of class backgrounds; from poor inner-city families to upper-middle-class suburban families (a disproportionate number come from middle-class homes). While the program is not specifically designed as a dual-diagnosis program, most of the teenagers served have been diagnosed with either a conduct disorder or an oppositional disorder. A small percentage have a major depression diagnosis. In the past, the program also has admitted a small number of adolescents on psychotropic medication, but in general, schizophrenic or psychotic adolescents are referred to other parts of the hospital. Many of the adolescents admitted have suicidal ideation, but those who display active suicidal behavior are referred to more secure lock-up wards in the hospital. Between one third and half of the teenagers come from homes with substance-abusing parents who generally are inconsistent and send mixed messages to their children. Most of the teenagers admitted are frequent users of cocaine: many of them are freebasing, although more and more are coming in with crack habits. All are polydrug users who began using drugs and alcohol in their early teens.

Program Description: Manor House is a comprehensive drug treatment program situated in a larger child-and-adolescent psychiatric hospital. This two-track program—adolescent 13-18 and young adult 18-22 — moves youngsters though a treatment continuum from short-term residential (24 beds), through day treatment (24 spaces), to intensive outpatient (20 patients) over the course of a year, although some require more time. The comprehensive program includes family education, treatment and training, small structured school classes with individualized programming, relapse prevention, stress management, counseling on relationship issues, 12-step recovery principles, a therapeutic adventure program, and creative art therapy.

Admission and Intake: The adolescents admitted to the program are referred by the courts, family members, emergency room personnel in other psychiatric hospitals, or by private practitioners. The intake involves a lengthy interview covering a range of topics from physical symptoms to relations with family and friends, legal and financial problems, and psychological health.

Treatment Options: If the youngster is accepted into Manor House, he or she might enter one of three tracks: short-term inpatient, partial hospitalization, or intensive outpatient treatment. Many of the youngsters are initially referred to the inpatient unit for between 7 and 45 days, but most stay for 6 weeks. During their inpatient stay, the adolescents are stabilized and begin to acknowledge their disease. They are required to go to seven meetings a week of NA or AA, either on or off site. During the day, the young patients attend 4 hours of schooling, which is coordinated with their home school. In the afternoon, they participate in group, individual, and family therapy. In addition to the therapy, they attend workshops on drug education, sexuality, and other key issues. Structured athletic programs, creative therapy, a music group, and biofeedback fill the remainder of their day and night. (The biofeedback helps reduce stress and craving for the drug.) The programs and therapy sessions share the common goal of developing the adolescent's confidence, communication skills, and effectiveness as an individual. Family involvement is considered to be a crucial element in the treatment approach. Recovery is contingent upon a family process involving education and the gradual reversal of the negative effects of substance abuse on the family unit. Family recovery is built around the creative development of an environment conducive to self-confidence, openness, support, and growth for all members.

After the 6-week inpatient program, many youngsters who live in the area go home but continue to participate in the partial hospitalization/day treatment program. This component involves a 42-hour-a-week program that stresses relapse prevention and life-skills development. Many youths remain in this program for between 9 weeks and 6 months, continuing the therapies begun in the residential stay. In this stage, a special planning and placement team prepares the adolescent to return to his or her school. If the home school is particularly drug-infested, the team may decide that it is in the best interest of the young person to stay longer in the day treatment program.

Aftercare: After leaving day treatment, the adolescents continue working with their therapists in individual, group, and family sessions, or they may move into therapy with a local community mental health provider. The patient's primary clinician acts as a case manager through the entire continuum of services, working with the school, the family, and other agencies.

Funding: Manor House is funded through multiple streams. Approximately 60 percent of the patients have private insurance, which pays for residential and day treatment and outpatient therapy under different provisions of the policies. Twenty percent of the adolescents are funded through

State Medicaid and city welfare, under the rehabilitation option. The remaining adolescents are either self-pay or receive free care from a charity allocation.

Therapeutic Foster Care

Morrison Center Breakthrough Program

Professional/Therapeutic Foster Parents
3390 SE Milwaukee Avenue
Portland, OR 97202
Contact: Betty Barron
(503) 231-4000

Case History: Greg was given the option by his probation officer of attending either the Breakthrough Center or the State training school. At 16, he had been convicted of five felony offenses, including burglary and car theft. He left school at the age of 14 and had been unable to hold a job for more than 30 days. He comes from a socially stressed family. His father is an alcoholic who has not been present in the home since Greg was 8. His mother, who alternately treats him as child and parent, has had difficulties with relationships since her husband left. On one occasion, one of his mother's boyfriends sexually molested him. His mother is currently involved in a treatment program for codependency. Greg's parole officer referred him to the Breakthrough Center because of his drug and alcohol use and the codependency problems in his family. Greg talks about returning home to take care of his mother when he has completed the program at the center.

Program Philosophy: The Morrison Center Breakthrough Program is a private, not-for-profit agency that uses a novel approach in treating substance-abusing, criminally involved adolescents. Before this program was established, these troubled youth spent up to 2 years or more in the State training school, with little chance of receiving treatment for their substance abuse and emotional problems. The Breakthrough approach to residential treatment focuses on housing adolescents in "proctor" foster homes for the first 6 months of treatment. The proctor home provides a more natural living environment in which the youngsters live a clean and sober 12-step lifestyle. The proctor parents are themselves recovering alcoholics or drug abusers. The teenagers come to the center for 56 hours a week of a comprehensive treatment program focusing not only on drug and alcohol addiction, but also on sexual abuse victim and offender issues, criminal thinking patterns, social and living skills education, and academic achievement.

Population: The Breakthrough program serves adolescents between 12 and 19 years of age. The average age is 16. Of the 28 adolescents currently served, over half are male and about a quarter are African-American, Latino, or American Indian. The young people come from very troubled families. Between 50 and 65 percent of the teenagers' fathers and 30 percent of the mothers have arrest histories. In most cases one or both parents are problem alcohol or other drug users. Just under half of the young people served in the program were living in stepfamilies, in foster care, or in a residential setting at the time of admission. Between 35 and 40 percent have been hospitalized in psychiatric hospitals for drug or alcohol treatment. Many of the young people have experienced significant losses during their short lives. According to the director of the program, these youngsters express their grief and anxiety through high-risk acting out behavior. One of the requirements for admission to the program is a DSM-III diagnosis of substance or alcohol abuse or dependency, and many of the youngsters have additional psychological problems, such as anxiety, depression, and oppositional behavior. Many left school at 14 without completing eighth grade. Approximately one-third have suicidal ideation, and another third have attempted suicide. Their drug use has moved into the middle and late stages of addiction. Twenty-five percent are in the late stages of addiction, which involves physical deterioration and major health problems. They are polydrug users, with as many as 35 percent involved in IV drug use. They are, in other words, extremely troubled young people.

Program Description: The juvenile court system is the exclusive referral agency. The program has three priorities for admission: adolescents who have been convicted of a number of felonies but have been diverted from the training school by the courts, adolescents on probation who are in danger of being committed, and adolescents who are serving time in the State training school, but are in need of intensive alcohol and substance abuse treatment. Assaultive teens are screened out.

The intake assessment consists of life histories: family patterns, sexual abuse, level and patterns of drug and alcohol use, school and work histories. At the end of the intake screening, the young person is given a one-page writing assignment that includes family history and personal commitment to recovery. Admission is contingent on completion of the assignment. Although Breakthrough excludes youngsters who require psychotropic drugs to control depression or other mental illnesses, they will work with staff psychiatrists to wean those patients able to function without medication. Once the intake is completed and the young person is accepted, the staff meet to decide on the best placement. The adolescent is placed with therapeutic foster parents or in

proctor homes for the duration of the first two phases of the treatment.

Treatment Process: During Phase I (the first 90 days of intensive treatment) the young person attends the Morrison day treatment center from 8:00 am to 5:30 pm. In the initial phase, the adolescents are accompanied to and from the center by their proctor parents. Their day at the center begins with breakfast and participation in a daily motivation and goal-setting group, followed by clean-up. From 9:00 to 10:00 3 days a week, they participate in drug and alcohol education programs. The remainder of the morning is spent on school activities. The in-clinic school has a teacher whose salary is paid by the Portland public schools. After lunch, recent arrivals have chore responsibilities. Most afternoons between 1:00 and 3:00 the teenagers have recreational activities that might include swimming or working out in the weight room at the local YMCA, community volunteering, or playing volleyball in the nearby park. In the late afternoon they return to the center for group sessions that focus on problem-solving and compromise strategies. The aim of the group is to move the youngsters away from their self-centered and self-destructive behavior. On Mondays and Tuesdays the sessions focus on sexuality. During these groups, sex and AIDS education is provided and issues of relationships and boundaries are discussed. In the evenings, the young people attend AA, NA, or other 12-step meetings 4 nights a week.

During the second 90 days (Phase II) the youngsters are reintegrated into schools in the community or attend a GED course at the local community college. During this stage, they "ride the buses," that is, they are given greater responsibility. After school they return to the day treatment center for group therapy and recreational activities. By this time, the group sessions are dealing with issues of denial and codependency.

Phase III is basically transition services and aftercare. The teenagers move back home or into an apartment if home is not an option. They continue to come to group sessions and/or to alumni meetings and continue their contact with the 12-step groups that began during the first phase.

Proctor Families: What makes this program unique is the use of proctor families instead of placing the teen in a residential setting. The proctor parents offer an example of the possibilities of living free of drugs and alcohol. They are empathic with the youngsters because most are themselves recovering alcoholics or drug users who have been clean and sober for more than 2 years. The proctor families are certified by the Oregon Children Services Division and are paid $950 per month per adolescent. One family cannot take more than two teenagers at any one time, and these are required to take at least one weekend a month off. The success of the proctor model is in part due to the extensive training that the Morrison Center provides the parents, many of whom came from socially stressed families.

There are many advantages to the proctor or foster parent model. The cost of the program is far less than it would be if the youngsters were placed in residential settings. Living and interacting with adults who are working through the 12-step program and who are active participants in the 12-step community provides the youngsters with models and alternative sets of values and behaviors.

Links with the Community: The program has forged links with the community colleges, alternative schools, and other educational institutions in the city. There is a strong working relationship with the local YMCA.

Funding. The program is funded by a contract with the Oregon Children Services Division. The Portland public schools subsidize the educational component of the program. They receive no funds from State alcohol and drug abuse agencies.

Therapeutic Communities

Amity, Inc.

Residential Therapeutic Community for Criminally Involved Adolescents
P.O. Box 60520
Tucson, AZ 85751-6520
Contact: Rod Mullen
(602) 749-5980

Case History: At the time she entered Amity, Maria was 14 years old. She is of Hispanic and American Indian origin. When she was interviewed at the juvenile institution for girls, she admitted to "chipping" heroin; actually, she had been addicted to heroin for a year. Maria was at Amity for several months before admitting this and admitting that her mother was currently in prison. Maria had a hard time trusting the staff members; she found it easier to speak with other members of the program first. As she began talking about herself in groups, she disclosed that she had been molested as a child. Her mother, an alcoholic, took her to bars or dropped her off with relatives for varying lengths of time. During the time that she was with relatives, several of her cousins molested her. Maria's father and mother were not married. During her 13-year stay with her mother, her parents continually fought, separated and were reunited. At 13, Maria was sent to a boarding school because she was not attending classes at the public school. Her grandmother, the only person who instilled a sense of "family" in Maria, died while she was there, at which point she began using hard drugs. After she came back from the boarding school, Maria began associating

primarily with juvenile delinquents and drug users. She moved in with a 19-year-old dealer and began using heroin. At Amity, Maria was initially involved with a group of adults in an intensive curriculum on family dynamics. After completing this course, she worked with a group of young women, role-modeling changed image, group skills, and work habits. She participated in 10 workshops on a variety of topics that last from 3 to 7 days. At 16 she was unable to be reunited with her family. She moved into the home of a staff member who lives at the facility. She remained at this home until she graduated from Amity 1 1/2 years later. Maria is working toward attaining her high school equivalency and is working in the Tucson area.

Program Philosophy: Amity's Adolescent Treatment Program was established to respond to the chronic lack of substance abuse treatment for juveniles in correctional institutions. These facilities typically do not take advantage of institutional time to begin intensive drug treatment for juveniles with identified drug abuse problems. To address this multiple-risk population, Amity has developed a holistic approach including self-help techniques, vocational and special education, intense socialization, and strong peer modeling. This not-for-profit agency also runs a school-based intervention program described above.

Population: Amity's treatment program serves severely affected, usually criminally involved, male and female substance abusers from ages 12 to 18. The young people in the residential communities are disproportionately Latino and American Indian. At least one parent in most of the families has a history of chronic alcohol and drug abuse. Many of these young people have used drugs and have been criminally involved from the ages of 9 or 10 years and have failed in other treatment settings. Approximately 75 percent of the adolescents are referred by the Arizona Department of Corrections. Amity does not accept adolescents on psychotropic drugs or young people whose mental illness would prevent them from participating in crucial elements of the program activities.

Program Description: In the current treatment model, the Arizona Department of Corrections screens youth offenders who are serving time in one of three Department of Corrections institutions. Amity begins to work with those who are in need of substance abuse treatment within the correctional institutions before their discharge.

Amity uses psychodrama and other techniques to help resolve negative experiences, as many of the young people come from abusive, violent, and sexually confused families. Schooling is provided at the appropriate grade level as well as vocational education, sports and recreation, and expressive opportunities such as music, art, and drama. Amity has found that video playback is an effective, nonconfrontational method of giving feedback on behavior. The therapeutic model used in the residential community-based phase is based on Kohlberg's stages of moral development. Adolescents are provoked to see the conflicts between their behavior and the organization of the community or society. The program encourages understanding through role-playing. The goal is the development of social and moral maturity.

Residents are required to take an active part in maintaining and repairing the facility. They help prepare the meals and become involved in all facets of the adult working world associated with the facility. Amity staff work closely with the Department of Corrections. For example, Amity does cross-training with correctional and probation officers to promote respect and understanding among providers. Families who are willing participate in counseling and family workshops to prepare themselves for better functioning and support of the youth in treatment. Those youths who will not be returning to the family are prepared for independent living with meaningful vocational training. Depending on the progress made by the young person, he or she may move either forward or backward in the program. For example, if an adolescent is in trouble in the transition stage, he or she can be moved back to the residential or even the institutional phase for stabilization.

Admission and Intake: On their release from the State correctional facility, young people enter the therapeutic, community-based phase of the program. In this phase, the adolescents must work through three stages: orientation, community class, and senior class. After they have successfully completed the treatment, they may return to their families, be placed in therapeutic foster care, or, if they are old enough, begin independent living with continued aftercare. Although Amity provides all treatment services, the program is designed to involve correctional officers in a very close working relationship with counselors and therapists through the treatment cycle.

The aim is not rehabilitation, but habilitation, as many of these youngsters have not been socialized appropriately, nor have they experienced anything like a normal family upbringing. The program involves a creative adaptation of the therapeutic community that has proven effective with adult substance abusers—a model of public/private cooperation to reduce criminal activity and drug use, and a model of continuity of

care provided by a single agency that reflects the needs of serious adolescent substance abusers for long-term treatment and reintegration into the community. The program also works with families, beginning while the teenager is still in the correctional institution, to foster better treatment planning and better outcomes.

Staffing: Amity is staffed by a combination of former-addict counselors, who receive professional certification by Therapeutic Communities of America, and academically trained professionals. The staff participates in two intensive retreat/workshops each year to sharpen their skills and reflect on their own emotional lives. Family dynamics are stressed.

Amity's family approach is designed to promote bonding between adolescents and positive adult role models. Adults frequently move between program elements and follow up on youths who move to different program components. Bonding is also encouraged among young people who are advanced in their treatment.

HIV/AIDS Education: Amity has a program of HIV/AIDS education that has been developed to meet the needs of adolescents. The educational component is repeated frequently throughout the transition and aftercare phases.

Funding: The Adolescent Treatment Program is funded primarily by the Arizona Department of Corrections, with additional support from the State Supreme Court, Indian tribes, the Department of Economic Security, and private agencies. Currently the program serves about 90 young people with a projected increase to more than 250 by 1990 in the various phases from residential to aftercare.

Pahl House—A Residential Chemical Dependency Program for Youth

Residential Therapeutic Community and Transitional Apartments
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Case History: Bill's parents were divorced when he was 6 years old. His father, who is a blue collar worker, has not been involved in his life. He was sexually abused by a family friend. He first started experimenting with drugs when he was 8 years old; since then he has been involved in burglary to support his drug habit. At 15 he dropped out of school; at 17 he was on probation. He has been in front of the family court judge on three occasions. He had been in outpatient treatment and in a 30-day inpatient clinic. The judge required him to enter a drug treatment program or receive a mandatory sentence.

Program Philosophy: Pahl House is an intensive, long-term program for adolescents with alcohol and other substance abuse problems. According its director, "Most adolescents need a long-term treatment program when suffering from chemical dependency. Two years in our system, both the residential community and transition apartment, builds a stronger base and teaches community skills to support a life of sobriety."

Population: This unusually long-term program is for New York State residents and is designed for both males and females, 13 to 18 years old, who have histories of chemical dependency and are unable to benefit from outpatient treatment.

Program Description: Central to the Pahl House philosophy is the idea that for many, or even most, of the teens they admit, chemical dependency is an attempt to separate from the family. As a result, a pivotal aspect of the treatment program is teaching residents and their families new ways of relating and letting go.

Peer Culture: Residents attend daily group therapy sessions that help them to identify and express their feelings. In the group, they support and confront each other, developing a positive peer culture. The peer culture that develops in the group not only encourages youngsters to help themselves but illustrates the value of helping others, which builds self-esteem and emotional strength. Along with group therapy, each resident has an individual counselor with whom he or she bonds during one or more weekly sessions. Pahl House has private classrooms with certified teachers who offer instruction in coursework from previous schools, preparation for equivalency exams, remediation, and tutoring in computer skills.

Normal Adolescent Development: Pahl House has confronted the problem of the discrepancy between normal adolescent development and the requirements of a residential treatment program. Although adolescents are generally learning to separate and to make their own decisions, traditional therapeutic communities demand obedience and unquestioning acceptance of community rules. This program provides students room later in the treatment to question authority and to separate from adult influences so they can practice appropriate developmental behavior.

The treatment program helps residents to identify and grieve the loss of the chemical, in the belief that without recognizing how important drugs or alcohol were in the their emotional life, addicted teens may relapse. Instead of returning to the chemical to reduce the pain of the lost relationship, the treatment program provides a supportive context in which to grieve. Energy attached to the lost

chemical is channelled into healthy relationships as an integral part of the recovery process.

The treatment program encourages residents to learn the signs of relapse in order to control their behavior. The focus during times of relapse is on charting acting out behavior and talking with clinical staff to get a more in-depth insight and knowledge of their relapse issues. The focus is not on punishing relapse behavior, but on helping residents deal with these issues when they arise in the future.

Transitional Apartments: Most of the adolescents Pahl House serves are unable to return home because of the high risk of relapse in their former communities, schools, and peer culture. In order to deal with this problem, Pahl House has opened a transitional apartment program for adolescents 16 and older. The staff have observed that young people who remain in the program for a second year have a much higher rate of sobriety than those who do not. According to the director, in the two years that the transitional apartments have been operating, none of the 10 adolescents who have gone through the transitional apartment and related treatment has relapsed.

Funding: Pahl House is jointly funded by the New York Division of Substance Abuse Services and the Division of Alcoholism and Alcohol Abuse.

State-level Initiative: Wraparound Services for Difficult-to-serve Adolescents

The Alaska Youth Initiative (AYI)

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The Alaska Youth Initiative (AYI) represents a radical new direction for the delivery of services for multiproblem adolescents. The initiative is the result of a Children and Adolescent Service System Program (CASSP) effort that brought together people from the Alaska Department of Education and the Division of Mental Health and Developmental Disabilities to coordinate services for adolescents who were being served out of State. Some of these youngsters were in residential mental health and substance abuse programs costing more than $90,000 per year.

Although the youngsters served under the AYI have a wide variety of presenting problems, they share a number of common characteristics. All have had contact with multiple service agencies over an extended period. All have exhausted existing options at both the local and State levels. These difficult-to-serve youngsters are referred to an interdepartmental team at the State level, which constructs a service plan to maintain them in their communities. Of the approximately 75 young people whose cases have been reviewed by the interdepartmental team, about 50 percent are Alaskan natives. Substance abuse is a problem in over 67 percent of the youths in the AYI program. Many of them have dual diagnoses, including major psychiatric and chemical dependency diagnoses. Over 50 percent of the adolescents have been legally confirmed as being victims of sexual, emotional, or physical abuse.

The Inter-Departmental Team works with local interagency groups to review individual cases of youths who have not succeeded in the traditional service system, to determine whether the youngster meets the criteria for the Youth Initiative.

There are seven basic principles that underlie the Youth Initiative:

- The Initiative functions as a gatekeeper to ensure that youths are not sent out of State and, where possible, are served within 100 miles of home.
- Consensus must be reached among all the service providers.
- Services must be determined by the adolescent's needs. These are often referred to as "patient-centered" services or "wraparound" services.
- Services should be in as normal a setting as possible. Following the principle of normalization, congregate living in large institutional settings is inappropriate.
- Services should be provided in the least restrictive environment. This means that intensive services should be implemented in community and even home settings.
- Service planning must take into account chronicity. These young people will need services and support as adults. Frequent relapse and other problems must be anticipated.
- An unconditional care attitude must be adopted. If a treatment modality does not work, the focus must be on finding or developing one that does.

What makes AYI unique is the varied interventions that are used. The basic principle behind AYI is that treatment must be flexible, personalized, and as close to the youth's original community as possible.

According to a follow-up study, alcohol and drug use for treated adolescents decreased, as did running away, assaultive behavior, property damage, contact with police, and suicide attempts.[28] The average cost of providing these services is $40,562 per child per year.

Chapter 4—Recommendations

The following recommendations are a synthesis of comments and perspectives from administrators, counselors, and clinicians interviewed while gathering data on programs. Because of the lack of systematic outcome data, these recommendations reflect the perspective of service providers based on their practical experience.

Project Design

- Programs that serve chronic adolescent substance abusers should adopt a design that is intensive and long enough to ensure that changes are internalized. The length of treatment should not be prescribed; rather it should depend on variables such as severity of addiction, mental health, and the adolescent's social context.
- Aftercare is a critical component. Many youngsters who complete treatment relapse upon returning to the original environment. Strong transition and aftercare components can reduce the chance of relapse and help to ensure continuity of treatment goals. Specifically allocated funding streams should be made available.
- HIV/AIDS education should be provided throughout the program. It must be geared to the adolescents' intellectual capacity and be culturally sensitive. Educational efforts focusing on AIDS must be coupled with strong open-ended educational efforts focusing on the dynamics of relationships and the responsibilities associated with relationships.
- Programs must address issues of culture and the economic realities of adolescents' lives. African-American and other ethnic communities have a tremendous need for services and the expertise of good treatment providers, but these providers must learn from the community how to deliver the service in a way that will be accepted. Ethnically diverse therapists must be hired and trained to serve as role models.
- It is critical that all adolescents seeking treatment for substance abuse be assessed for a history of sexual, physical, and psychological abuse.
- Therapeutic approaches should treat the whole person through comprehensive, integrated services that are easily accessible. A wide range of services and activities (special and vocational education, birth control services, recreational activities) enable adolescents to explore alternative lifestyles, engage in constructive relationships, and plan for independent, drug-free living.
- With a difficult-to-serve population, such as sexually abused substance abusers, outside advocates who strongly support and encourage participation are key. Here the juvenile court system, social services, and families play a central role.

Staff Training and Development

- Staff who work with adolescents should undergo extensive and intensive training in family dynamics so that they do not, inadvertently, reproduce the dynamics of the codependent in families.
- All staff should receive cross field training. Substance abuse counselors should attend workshops on mental health issues (normal adolescent development, depression, anxiety) and mental health workers should have a clear understanding of the substance abuse field (e.g., enabling concepts) to encourage mutual respect and a clearer understanding of the dynamics of treating mentally ill, substance-abusing adolescents.

Work with Families

- Many of these adolescents come from alcohol- and drug-dependent families. In general, the worse the home situation, the less effective the treatment, because addicted parents are often threatened by the recovery of a member of the family. Attempts must be made to provide interventions for parents who abuse drugs and alcohol.

Endnotes

1. Based on a case study provided by a psychiatric nurse, Montefiore Hospital, Bronx, September 1989.

2. In this study, we use the term "substance abuse" to refer to both alcohol and drug abuse and chemical dependence. "Adolescents with behavioral and emotional disorders" refers to those children who have DSM-III diagnoses as well as those not diagnosed, but displaying the same characteristics as diagnosed children.

3. Plaut (1989), p. 6. This growing phenomenon has been clearly documented in the adult population. A recent ADAMHA-funded study found that 50 percent of the between 1.5 and 2 million chronically mentally ill population abuse illicit drugs or alcohol, compared to 15 percent of the population as a whole.

4. See, for example, a discussion of the problem in the adult population in Bogdaniak (1985) and Brown et al. (1989).

5. Christie et al. (1988) found that the median age for onset for anxiety disorder was 15 years; for major depression, 24 years; for drug abuse or dependency, 19 years; and for alcohol abuse or dependence, 21 years. These findings also suggest that young adults who have had a major depressive episode or anxiety disorder are at twice the risk for later drug abuse or dependence. Bachrach (1989) has pointed out the great difficulty in serving individuals with multiple disabilities. They become "the system's misfits" because their needs exceed the capacities of the service system.

6. Over 99 percent of deaths from substance abuse are attributed to tobacco and alcohol. (National Council on Alcoholism)

7. Newcomb et al. (1989) found a steady decline in use of most drugs since 1980. This study reported that teenagers are finding cocaine less attractive, with only 5.6 percent of high school seniors sampled having tried crack. On the other hand, the study found that there has been an increase of lifetime prevalence of cocaine abuse in some young adults, and that 5 percent of a sample of seniors acknowledged that they were daily drinkers. These findings partly confirm earlier studies. For example, Pascale et al. (1988) found that while frequent alcohol use has increased for both males and females between 1977 and 1986, frequent cocaine use for males has remained stable and has declined for females. Frequent marijuana use declined sharply for both males and females between 1977 and 1986.

8. Robert G. Niven (1989), "Adolescent Drug Abuse," cited in National Conference of State Legislatures, "Cost Effective Care Options for Emotionally Disturbed and Substance Abusing Adolescents."

9. Deykin's (1987) study of 424 college students, aged 16 to 19, from middle- and upper-middle-class families attending two Boston area colleges, found that the lifetime prevalence of alcohol abuse/dependence was 8.2 percent; substance abuse/dependence, 9.4 percent; and major depressive disorder, 6.8 percent. Subjects who report a history of alcohol abuse are four times as likely to have a history of major depressive disorder as subjects who have not abused alcohol. Of the 35 subjects who reported a history of alcohol abuse, 8 indicated a history of major depressive disorder and of the 40 subjects who reported a history of substance abuse, 8 indicated major depressive disorder. Eight subjects in the sample of 424 met the criteria both for alcohol and drub abuse. Five of the 8 also had another psychiatric disorder (MDD in 3, obsessive compulsive and phobic in the other 2). Half of the polydrug abusers had two or more psychiatric diagnoses and indicated an extraordinarily high level of psychopathology. The study also found that college students who meet the criteria for MDD and for alcohol or drug abuse are almost always subject to the depressive illness first and alcohol/substance abuse subsequently. In a more representative sample taken from the NIMH Epidemiologic Catchment Area Program, a subgroup of 4,779 respondents aged 18 to 30 were asked about the age of onset of their mental disorders and/or substance abuse. Christie et al. (1988) found that almost 6 percent of the subjects have a lifetime diagnosis of drug abuse or dependency, 13.3 percent have a diagnosis of alcohol abuse or dependency, and 5.8 percent have a diagnosis of major depressive episode. The study found a doubling of risk for subsequent drug use disorders in young adults who have had an earlier depressive or anxiety disorder. From a different perspective, one study found that almost 30 percent of adolescents entering treatment programs reported emotional or psychiatric problems as the major reason for their drug abuse. Sixteen percent of all adolescents entering treatment in the sample reported one or more suicide attempts and 20 percent had been treated for a mental health problem on one or more occasions (Friedman et al., 1985).

10. Klinge and Piggott (1986) conducted a study of 12-17-year-olds admitted to a psychiatric clinic. Of the 123 patients interviewed, they found that 39 percent reported minimal use of drugs. Thirty-seven percent of the young patients reported moderate use (more than 1 1/2 ounces of alcohol per day, and/or regular use of one nonprescribed drug, which had led to a verbal altercation within the family, on the job, and/or in school). Twenty-four percent of the patients reported heavy use (more than 1 1/2 ounces of alcohol per day, and/or regular use of nonprescribed drugs, and/or use of drugs in combination). Groves et al. (1986) conducted a study of patients admitted for the first time to a 13-bed adolescent unit of 130-bed teaching and research psychiatric hospital. Of the 204 adolescents between the ages of 11 and 17, 77 percent were diagnosed as suffering from one of the following: affective disorders, adjustment disorders, conduct disorders, personality disorders, and schizophrenia. Forty-five percent of the adolescents reported using at least one illicit drug (including alcohol) before admission. Marijuana was the most frequently used illicit drug; it was sued by 75 percent of illicit drug users. Alcohol was used by 64 percent of those using illicit drugs.

11. Leone et al. (1989) compared the use of cigarettes, alcohol, and marijuana in regular high schools and special high schools for severely emotionally disturbed students. They found that 17 percent of regular education students smoked cigarettes, while 65 percent of students enrolled in the special school smoked. Thirty-four percent of regular education students drank alcohol compared to 46 percent of the special education cohort. Six times as many severely emotionally disturbed students smoked

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marijuana compared to the regular education students. Although the number of students reporting use of cocaine, hallucinogens, inhalants, and prescription medications was small, students enrolled in the special school programs reported a higher prevalence and wider range of substance use. Although this study does not provide specific information of DSM-III drug and alcohol use disorders among students enrolled in special school programs for the seriously emotionally disturbed, it does indicate that students in a restrictive setting for their emotional or behavioral disorders might have a significantly higher prevalence of abuse and dependency than the nonspecial education population.

12. Friedman et al. (1985) found that white adolescents had a higher lifetime prevalence of illicit drug use than African-American or Latino youth.

13. See Knitzer (1982).

14. The following descriptions are based on Kusnetz (1986).

15. Newcomb (1989) recently warned that "There is a growing concern that for various reasons, not the least of which is the profit motive, treatment programs are purposefully blurring the distinction between use and abuse (any use equals abuse) and preying on the national drug hysteria to scare parents into putting their teenagers in treatment with as little provocation as having a beer or smoking a joint." (p. 246).

16. Plaut et al. (1989).

17. For example, the therapeutic communities in New York City are currently under enormous stress, so much so that in one, a patient had to be discharged so that a pregnant substance abuser could be accommodated. In many parts of the city, there are not beds for pregnant substance abusers. Plaut et al. (1989).

18. Another study found that as simple an intervention as a weekly family trip to the movies had a positive impact on drug use and resulted in a higher percentage of days in school when compared to individual treatment. Plaut et al. (1989).

19. Ibid., p. 13.

20. Ibid., p. 14.

21. Ibid., p. 71. According to Weithorn (1988), the growing trend in the field of adolescent mental health to inpatient hospitalization is neither beneficial nor cost-effective. There was an almost five-fold increase in the number of juveniles admitted to private psychiatric hospitals between 1980 and 1984. The type and degree of mental illness of many of the adolescents admitted to inpatient facilities are neither severe nor acute enough to warrant that degree of restriction. A large percentage are initially diagnosed as conduct disordered, personality or childhood disorder, or transitional disorder. Although these conditions cause real psychological pain to children, most do not require the restrictiveness of mental hospitals, as the children are not a danger to themselves or others. Finally, institutionalization has substantial negative effects on mentally ill adolescents. Research conducted in the last two decades has revealed that institutionalization may foster dependency, feelings of powerlessness, and helplessness.

22. Burns (1989), p. 74.

23. See Bernard (1987) for references to peer support groups as a model for prevention and treatment.

24. Based on a case history in *Inside The Door: A Center of Alternatives for Youth*, A Door publication. 1986.

25. Ibid., p. 26.

26. In 1987, New York State created the Task Force on Integrated Projects for Youth and Chemical Dependency. This body draws its members from State alcohol and substance abuse, mental health, and educational agencies. It provides funding for more than 80 integrated projects, including the West Prep program, Executive Park South, Box 8200, Albany, New York 12203. Contact: Gary Meier.

27. This approach is associated with the techniques practiced by Sciacca (1987) and others in the dual diagnosed adult population. The approach begins treatment with drug and alcohol education, which allows the client to benefit from participation even when he or she does not acknowledge a substance abuse problem. "This allows the client to feel her or his way into a recognition of the impact of drug and alcohol use on daily functioning and a commitment to, or at least a trial of, abstinence based on increased knowledge and understanding. At the same time, it allows the staff of the treatment program to address the issues of substance use or abuse without taking a more confrontational lien than the client can tolerate. To engage pre-abstinent clients and involve them in the ongoing treatment, it is necessary to modify traditional treatment approaches." (Brown, et al., 1989).

28. Burns (1989), p. 135.

Bibliography

Acoca, L. and Barr, J. *The Threshold Report: A Treatment Continuum for Chemically Dependent Adolescents from Low and Moderate Income Families.* Marin County, CA: Threshold for Change.

Bachrach, L., Sociological Factors Associated with Substance Abuse Among New Chronic Patients. In: S. C. Feinstein, (Ed.), *Adolescent Psychiatry: Developmental and Clinical Studies.* Vol. 16. Chicago: University of Chicago, 1989, 189-201.

Benard, B. "Peer Programs: The Lodestone to Prevention," *Prevention Forum* January 1988.

Beschner, G. M., and Friedman, A. S. "Treatment of Adolescent Drug Abusers," *The International Journal of the Addictions* 20(6&7):971-993, 1985.

Beschner, G. M., and Friedman, A. S. (Eds), *Teen Drug Use.* Lexington, MA: Lexington Books, 1986. 243 pp.

Bogdaniak, R. C. Emotional Disturbance and Substance Abuse/Addiction. ERIC ED281324.

Bogdaniak, R. C. Special Education Programming for the Dually Diagnosed Adolescent. ERIC EC191780.

Brown, V. et al. "The Dual Crisis: Mental Illness and Substance Abuse: Present and Future Directions," *American Psychologist,* March 1989.

Burns, B. and Taube C. A., "Mental Health Services for Adolescents" (Unpublished Manuscript) June 1989.

Christie, K. et al. "Epidemiologic Evidence for Early Onset of Mental Disorders and Higher Risk of Drug Abuse in Young Adults," *American Journal of Psychiatry* 145(8) August 1988, 971-975.

Congress of the United States, Office of Technology Assessment, Children's Mental Health: Problem and Services (December 1986).

De Leon, G., 1988. The Therapeutic Community and Behavioral Science. In: B.A. Ray, Ed. *Learning Factors in Substance Abuse.* (NIDA Research Monograph 84). DHHS Publication No. (ADM)88-1576. Rockville, MD: National Institute on Drug Abuse, 1988, 74-99.

De Leon, G., 1984. *The Therapeutic Community: A Study of Effectiveness.* In: Treatment Research Monograph Series, DHHS Publication No. (ADM) 84-1286. Rockville, Maryland: National Institute on Drug Abuse.

Deykin, E. Y. et al. "Adolescent Depression, Alcohol and Drug Abuse," *American Journal of Public Health* 77(2) February 1987, 178-182.

Fernandez-Pol, B., Bluestone, H. and Mizruchi, M. "Inner-City Substance Abuse Patterns: A Study of Psychiatric Inpatients," *American Journal of Drug, Alcohol Abuse* 14(1) 1988, 41-50.

Forman, S. G. and Linney, J. A. "School-based Prevention of Adolescent Substance Abuse: Programs, Implementation and Future Directions," *School Psychology Review* 17(4) 1988, 550-558.

Friedman, A. S. and Glickman, N. W. "Program Characteristics for Successful Treatment of Adolescent Drug Abuse," *Journal of Nervous and Mental Disease* 174(11), 1986, 669-679.

Friedman, B. J., Quick J. , Mayo, J. et al. , "Social Skills Training Within a Day Treatment Program for Emotionally Disturbed Adolescents, *Child and Youth Services* 5 1983, 139-153.

Groves, J. B. et al. "Psychoactive-drug use among adolescents with psychiatric disorders," *American Journal of Hospital Pharmacy* 43 1986, 1716-1717.

Hawkins, J. D. et al. "Delinquency and Drug Abuse: Implications for Social Services" King County Division of Alcohol and Substance Abuse Services, 1988 (Unpublished manuscript).

Hawkins, R. O., "Adolescent Alcohol Abuse: A Review," *Developmental and Behavioral Pediatrics* 3(2), June 1982, 83-87.

Institute of Medicine, *Research on Children and Adolescents with Mental, Behavioral, and Developmental Disorders: Mobilizing a National Initiative* (Washington D.C.: National Academy Press, 1989).

Klinge, V. and Piggott, L. R. "Substance Use by Adolescent Psychiatric Inpatients and Their Parents" *Adolescence* (XXI)82 1986, 323-331.

Knitzer, J. *Unclaimed Children: The Failure of Public Responsibility to Children and Adolescents in Need of*

Mental Health Services, Children's Defense Fund, 1982.

Kusnetz, S. "Services for Adolescent Substance Abusers," in Beschner, G. M. and Friedman, A. S.(eds) *Teen Drug Use* Lexington, MA: Lexington Books, 1986. 243 pp.

Leone, P. E, Greenberg, J. M., Trickett, E. J., "A Study of the Use of Cigarettes, Alcohol, and Marijuana by Students Identified as Seriously Emotionally Disturbed," *Counterpoint* 1989, 6-7.

Maddahian, E., Newcomb, M. D., and Bentler, P. M. "Adolescents' Substance Use: Impact of Ethnicity, Income and Availability," *Advances in Alcohol and Substance Abuse* 5(3): 63–78, 1986.

National Conference of State Legislatures, "Cost-Effective Care Options for Emotionally Disturbed and Substance Abusing Adolescents" Presented for the Alcohol, Drug Abuse, and Mental Health Administration's Conference on "Treatment of Adolescents with Alcohol, Drug Abuse, and Mental Health Problems," October 2, 1989.

Newcomb, M. D., and Bentler, P. M. "Substance Use and Abuse Among Children and Teenagers," *American Psychologist* 44(2): 242–248, 1989.

Newcomb, M. D., and Bentler, P. M. *Consequences of Adolescent Drug Use: Impact on the Lives of Young Adults* (Newburg Park, CA: Sage Publications, 1988).

Niven, R. G. "Adolescent Drug Abuse," *Hospital and Community Psychiatry* 37(6) 1986, 596-607.

Plaut, J. and Kelley, T. *Childwatch: Children and Drugs* (NY: Interface, June 1989).

Pascale, P. J. and Sylvester, J. "Trend Analyses of Four Large Scale Surveys of High School Drug Use, 1977-1986," *Journal of Drug Education*, 18(3) 1988, 221-233.

Rygelwicz, H. and Pepper, B., "Compromised Development: The Complex Plight of Young Adults with Mental/Emotional Disorders" In: S. C. Feinstein (Ed.), *Adolescent Psychiatry: Developmental and Clinical Studies*. Vol. 16. Chicago: University of Chicago, 1989, 279-287.

Saxe, L.M, Cross, T. Silverman, N. *Children's Mental Health: Problems and Services. A Report by the Office of Technology Assessment* (Durham, NC: Duke University Press, 1987).

Sciacca, K. "Alcohol/Substance Abuse Programs at the New York State Psychiatric Centers Develop and Expand . . ." *AID Bulletin Intervention with the Disabled*, 9(2), 1987.

Shedler, J., and Block, J. "Adolescent Drug Use and Psychological Health." *American Psychologist* 45(5):612-630, 1990.

Stamford, P. D, Johnston, R. L. And Sprott K., "An Analysis of Drug-Related Admissions on an Adolescent Service," *Journal of Adolescent Health Care* 3 1982, 114-119.

U.S. Department of Health and Human Services. *HHS News* [News release on 1989 National High School Senior Survey]. February 13, 1990, 28 pp.

Washton, A. *Cocaine Addiction: Treatment, Recovery and Relapse Prevention* (New York: W. W. Norton & Co., 1989). 243 pp.

Weithorn, L. A., "Mental Hospitalization of Troublesome Youth," *Stanford Law Review* 40(3) 1988, 733-838.

Zacher, J., Pepper, B. and Kirshner, M. "Neuropsychological Characteristics of Young Adult Chronic Psychiatric Patients: Preliminary Observations," *Perceptual and Motor Skills* 68 1989, 391-399.

*U.S. GOVERNMENT PRINTING OFFICE: 1991--517-025/48359

DHHS Publication No. (ADM) 91-1744
Alcohol, Drug Abuse, and Mental Health Administration
Printed 1991